

*Shasta Children and Families First
Commission*

"HOW ARE THE CHILDREN?"



STRATEGIC PLAN

August 23, 2000

Shasta Children and Families First Commission

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Special thanks to Daphne Stearns for her assistance with focus groups

ACKNOWLEDGEMENTS

The Shasta Children and Families First Commission extends sincere appreciation to the many parents of young children who so openly shared their thoughts, experiences and ideas with us. Your observations and comments have been a driving force behind the formulation of this plan.

Thank you to the following organizations who offered the participation of their staff, use of facilities and other assistance to our planning process:

ACORN	AAUW Serendipity Playgroup	CalWORKS Partnership	Crossroads Clinic
Early Head Start	Even Start, Rother School	FaithWORKS	Fall River Unified School District
Family Planning, Inc.	Family Services Agency	Far Northern Regional Center	First Baptist Church of Shasta Lake City
First United Methodist Church	Foster Grandparents	Grassroots for Kids	Great Beginnings
Healthy Start	Infant-Toddler Parenting Center	Intermountain Family Practice	Kids' Turn
Local Child Care Planning Council	Martin Luther King State Preschool	Mary Street School	Mayers Memorial Hospital
McConnell Foundation	Mercy Medical Center	Monte Vista School	Mountain View Continuation School
Northern Valley Catholic Social Services	Oak Run School	Pit River Indian Health Services	Private Industry Council
Redding Medical Center	Redding Rancheria Head Start	Salvation Army	Shasta Community Health Center
Shasta County Alcohol and Drug Program	Shasta County Child Abuse Prevention Council	Shasta County Children's Protective Services	Shasta County Community Mental Health
Shasta County Department of Social Services	Shasta County Family Child Care Association	Shasta County Migrant Education	Shasta County Office of Education, Early Childhood Services
Shasta County Public Health Department	Shasta County Women, Infants and Children	Shasta County Womens Refuge	Shasta Head Start
Shasta Healthy Families	Shasta-Trinity Medical Society	Shasta Consortium of Community Health Centers	Shingle Shack
Shingletown Medical Center	Southeast Asian Christian Ministries	Tri-Counties Community Network	

We also are grateful to the following individuals for their involvement and support

Carla Alexander	Robby Chow	Martha Daw
Cindy Dodds	Sandy Evans	Susan Fisher
Dean Germano	Margaret Jensen	Holly Lenz
Alice McFadden	Jenni Middleton	Lee Miller
Chris Moats	Elizabeth Ratliff	Jean Salerno
	Jane'tt Taylor	

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"HOW ARE THE CHILDREN?"

How Are The Children?

Among the most accomplished and fabled tribes of Africa, no tribe was considered to have warriors more fearsome or more intelligent than the mighty Masai. It is perhaps surprising then to learn the traditional greeting that passed between Masai warriors. "Kasserian ingera," one would always say to another. It means, "and how are the children?"

It is still the traditional greeting among the Masai, acknowledging the high value that the Masai always place on their children's well-being. Even warriors with no children of their own would always give the traditional answer. "All the children are well." Meaning, of course, that peace and safety prevail, that the priorities of protecting the young, the powerless are in place, that Masai society has not forgotten its reason for being, its proper functions and responsibilities. "All the children are well" means that life is good. It means that the daily struggles of an existence, even among a poor people, do not preclude proper caring for its young.

I wonder how it might affect our consciousness of our own children's welfare if in our culture we took to greeting each other with this same daily question: "And how are the children?" I wonder if we heard that question and passed it along to each other a dozen times a day, if it would begin to make a difference in the reality of how children are thought of or cared for in this country?

I wonder if every adult among us, parent and non-parent alike felt an equal weight for the daily care and protection of all the children in our town, in our state, in our country. . . I wonder if we could truly say without hesitation, "the children are well, yes, all the children are well."

What would it be like if the President began every press conference, every public appearance, by answering the question, "And how are the children, Mr. President?" If every governor of every state had to answer the same question at every press conference: "And how are the children, Governor? Are they well?" Wouldn't it be interesting to hear the answers?

Excerpted from a speech by the Rev. Dr. Patrick T. O'Neill, First Parish Unitarian Universalist Church in Framingham, MA.

EXECUTIVE SUMMARY

Just imagine! Imagine what our communities would be if we placed a priority on our youngest children – those yet developing in the womb and those in the most critical period of brain development and social-emotional development – those children between the ages of 0-to-5 years old. What if our youngest children were treated as treasures by their parents and caregivers as well as by members of the general community? What if their environments allowed them to establish trusting, loving relationships? What if they were well-nourished and cognitively stimulated? What if they were raised in healthy communities --free of violence, free of smoke, free of substance abuse? What if their health and development were attended to in ways that ensured their optimal physical, social, emotional, mental, spiritual and intellectual functioning?

Just imagine! Imagine what our communities would be if we put children and their families first; if we gauged the well-being of our communities by how we answer the question: *how are the children?*

It is this image that drives the work of the Shasta Children and Families First Commission. We are dedicated to a community that values early childhood development and learning.

OUR VISION

Shasta County is a community that works together to create safe, nurturing environments that allow all young children to learn, play and reach their potential as contributing members of society.

OUR MISSION

The Shasta Children and Families First Commission provides leadership and accountability in promoting community attitudes, practices and resource allocations that support the healthy development of children in the prenatal period to 5 years of life. We strengthen community knowledge of this period and our actions support community-wide systems of integrated prevention and early intervention practices.

Strategic Planning Process

It is from this perspective that our planning process proceeded. We wanted to know what would characterize a community whose attitudes and behaviors demonstrated a value for early childhood. What would be the condition of our children and families? What would such a community *look like* and how can we best utilize Proposition 10 generated revenues to move us closer to our vision?

First, to establish a common framework of information from which to work, the Commission examined issues, and effective practices and best measurements related to family planning, prenatal care, bonding and breastfeeding, early intervention, child care and school readiness. We

also engaged experts in the community to assist in identifying measures that would indicate how well our population was doing with regards to healthy practices in each of these areas of early childhood development

Based on this research and related discussions, the Commission concluded that in order to make a significant and lasting difference in the lives of young children, an overall heightening of awareness and appreciation of the critical development occurring in the prenatal-to-five year old period was to be our priority. This became the basis for our organizational vision and mission.

We also needed to know how our young children and their families currently were faring and for this we turned to a compilation of data from existing community assessments. Within the past 3-4 years, over a dozen assessments of Shasta County had been conducted by private and public entities at the local and state level. We chose to utilize this existing data, gleaned from it information specific to young children and their families. This *community assessment* gives us a snapshot of the existing health status and patterns of behavior of families with young children.

Such quantified data is important – but insufficient. The Shasta Commission is committed to community involvement and to enacting a plan that is responsive to the community’s perspective. As such, the Commission staff conducted twenty-one focus groups throughout Shasta County -- sixteen of these groups were with parents of young children, in which a total of 96 parents participated. The remaining five groups allowed us to hear from 92 service providers who work with young children and their families throughout the county. We learned from the people who live within the communities of Shasta County what is important, what is useful, what is needed and what a community that values young children would look like.

While a couple of physicians participated in our provider focus groups, we sought a broader perspective from the medical community. To this end, a written survey was designed and distributed to physicians with assistance from the Shasta-Trinity Medical Society.

Based on the input received from our community engagement efforts and the information gathered from our research, the Commission identified four goals and specific objectives related to each.

The goals of the Shasta Children and Families First Commission are:

Community understands and values early childhood development and child learning

Strategic Result Areas: Improved Family Functioning; Improved Systems for Families

Services and resources are accessible

Strategic Result Area: Improved Systems for Families

Policies and funding resources are focused on children age 0-to-5 years old

Strategic Result Area: Improved Systems for Families

Children and families are safe and children are physically, mentally, emotionally, socially and spiritually healthy and ready to learn

Strategic Result Areas:

Improved Family Functioning; Improved Child Development; Improved Child Health

The Commission then appointed an ad hoc advisory committee to 1) review the goals and objectives, 2) formulate strategies for their accomplishment, and 3) further formulate our expected results and measurable indicators. The ad hoc advisory committee consisted of 28 people and was comprised of parents of young children, persons interested in and informed about early childhood, and providers who serve young children and their families. It represented a cross-section of the community -- geographically, professionally and culturally.

The parameters of the committee's work were to aim for attitudinal and behavioral community change; seek integration of services; incorporate the work of collaboratives and networks of community members; and to maintain a prevention and early intervention orientation. In total, committee members devoted a combined 440 hours to these efforts.

The committee first formulated strategies directed toward systems change, capacity-building, parent education and support, public education, provider education and support, direct services and community development activities. These *strategic directions* will lead us to the accomplishment of each of our objectives. It then formulated methods the Shasta Commission could implement and support that will allow the specific strategies to be carried out. These methods, or *SCFFC Approaches*, provide the structure through which the Shasta Commission will conduct its work over the next one-to-five years.

Upon identifying the strategies and approaches for each objective, a task group within the advisory committee expanded upon the indicators and expected results previously identified by the Commission.

The results of their efforts is the following long-range plan to address the goals and objectives of the Shasta Children and Families First Commission.

Goals, Objectives and SCFFC Approaches

GOAL ONE

COMMUNITY UNDERSTANDS AND VALUES EARLY CHILDHOOD DEVELOPMENT AND CHILD LEARNING

Objective A

Leaders of foundations are educated about issues related to early childhood development

Objective B

Service providers are educated about issues related to early childhood development

Objective C

Parents and primary caregivers are educated about issues related to early childhood development

Objective D

Employers are educated about issues related to early childhood development and family needs

Objective E

Middle/high school age youth are educated about early childhood development

SCFFC APPROACH

1. Develop a public awareness and education campaign, utilizing various approaches and forms of media
2. Research and develop materials/references regarding the important issues/factors involved in early childhood development and child learning and ensure that these materials are included in all informational/educational SCFFC-supported efforts and programs
3. Develop a professional training and education project to:
 - a. identify and coordinate professional training and education resources
 - b. assess professional interests and educational needs
 - c. develop appropriate training/education plans, including the support of professional involvement in professional education opportunities
 - d. arrange for professional conferences, educational sessions, seminars, in-house staff training programs, etc.
 - e. evaluate training and educational offerings
4. Offer community-based workshops, employer seminars, public education workshops, programs and events, including programs designed for middle/high school aged youth
5. Offer training(s) and follow-up activities related to infant-to-5 year old *developmental assets* (e.g. Search Institute)
6. Support coordinated advocacy efforts to educate decision-makers, legislators, policy-makers & leaders regarding the impact of decisions on the 0-to-5 year old population

GOAL TWO

SERVICES AND RESOURCES ARE ACCESSIBLE

Objective A

Community-based groups focused on localized services for children aged 0-to-5 exist countywide

SCFFC APPROACH

1. Sponsor *community-building workshop(s)* (e.g. McKnight's, *Building Communities from the Inside Out*) including parents with children 0-to-5, business representatives and civic leaders.
2. Support pilot community-based projects utilizing community collaboratives and/or community-based partnerships
3. Ensure that SCFFC-sponsored collaboratives, partnerships and planning groups to include an empowering number of parents of young children under 5 years of age

Objective B

Information clearinghouse is developed

SCFFC APPROACH

1. Support the development and coordination of a referral information telephone line and website for families with children prenatal to 5 years old

Objective C

Increase access to affordable health care coverage

SCFFC APPROACH

1. Provide support for the coordination and collaboration of Healthy Families Enrollment Entities throughout Shasta County
2. Support a public awareness campaign regarding health coverage options

Objective D

Increase access to quality, affordable early care and education for infants and toddlers, sick children, children with special needs and children during non-traditional work hours

SCFFC APPROACH

1. Support the design of a county-wide centralized child care eligibility list
2. Support the development of neighborhood-based child care co-ops
3. Support development of a managed network of substitute early care and education providers
4. Develop effective incentives for early care and education providers

Objective E

Increase number of licensed early care and education providers

SCFFC APPROACH

1. Support development of a managed network of substitute providers of early care and education services
2. Develop effective incentives for early care and education providers

GOAL THREE

POLICIES AND FUNDING RESOURCES ARE FOCUSED ON CHILDREN AGE 0-to-5

Objective A

Community-based groups focused on policies and resources for children age 0-to-5 exist countywide

SCFFC APPROACH

1. Sponsor *community-building workshop(s)* (e.g. McKnight's, *Building Communities from the Inside Out*) including parents with children 0-to-5, business representatives and civic leaders.
2. Support the development of community-based policy and funding groups
3. Provide technical assistance regarding resource identification and development

Objective B

Local foundations, businesses, governments and organizations financially support and participate in programs focused on 0-to-5 year olds

SCFFC APPROACH

1. Support resource development efforts aimed at the development of funding and resource opportunities

Objective C

Employment policies/practices that support family needs are implemented

SCFFC APPROACH

1. Support the utilization of an *Employer Liaison* to work with the employer community to engage, educate and develop participation opportunities for employers or employer groups
2. Develop pilot project(s) with large, small and/or aggregates of employers

GOAL FOUR

CHILDREN AND FAMILIES ARE SAFE AND CHILDREN ARE PHYSICALLY, MENTALLY, EMOTIONALLY, SOCIALLY AND SPIRITUALLY HEALTHY AND READY TO LEARN

Objective A

Decrease child abuse, neglect and child experience of family violence

SCFFC APPROACH

1. Support development of regional and community-based collaborative(s) focused on prevention, identification and early intervention of child abuse, neglect and child experience of family violence.
2. Support development of parental support telephone line.
3. Support development of respite care.

Objective B

Decrease parental and family substance abuse and tobacco use, especially during the prenatal to 5 year old period

SCFFC APPROACH

1. Support a collaborative effort of agency and faith-based providers of prevention and early intervention services to develop community family centers that support sobriety and healthy family activities.
2. Support public education campaign(s) regarding substance abuse and tobacco use
3. Support parent education and support for tobacco and substance abuse prevention and cessation
4. Support effort to identify and provide interventions for substance abusing and smoking parents during pregnancy and perinatal period

Objective C

Increase duration of breastfeeding

SCFFC APPROACH

1. Develop a breastfeeding resource program with satellite site(s) in outlying area(s).

Objective D

Decrease rates of childhood anemia and obesity

SCFFC APPROACH

1. Support professional education and the development of appropriate intervention materials for use by registered dietitians, MDs and early care and education providers regarding early childhood anemia and obesity
2. Support community-based organizations to develop and offer nutritional education and physical activity opportunities for families with children 0-5 years old
3. Support the development of a public awareness campaign on issues related to early childhood anemia and obesity

Objective E

Decrease rate/severity of maternal depression

SCFFC APPROACH

1. Fund development of a Mental Health Initiative for prenatal to 5 years old, with emphasis on 0-3. Focus on:
 - a. decreasing rate and severity of maternal depression
 - b. identification, assessment and intervention services for young children at-risk of impaired attachment.
 - i. include focus on reattachment issues
 - ii. encourage and foster the father/child bond
 - iii. identification of pregnant mothers at risk of poor attachment

Objective F

Improve identification, assessment and intervention services for young children at risk of impaired attachment

SCFFC APPROACH

1. Fund development of a Mental Health Initiative for prenatal to 5 years old, with emphasis on 0-3. Focus on:
 - a. decreasing rate and severity of maternal depression
 - b. identification, assessment and intervention services for young children at-risk of impaired attachment.
 - i. include focus on reattachment issues
 - ii. encourage and foster the father/child bond
 - iii. identification of pregnant mothers at risk of poor attachment

Objective G

Improve language acquisition and family literacy

SCFFC APPROACH

1. Support the development and coordination of project(s) to increase in-home and in-community reading/language use with young children
2. Support project focused on adult language development (ESL and Adult Basic Education)
3. Support the coordination of multi-lingual services and availability of multi-lingual materials

Objective H

Increase the number and use of parks and recreational activities

SCFFC APPROACH

1. Support efforts to increase park equipment and free/affordable recreational activities appropriate for 0-to-5 year olds
2. Support development and coordination of free/affordable parent/child playgroups for 0-to-5 year olds
3. Encourage local sponsorship and/or reduced fees for recreational activities appropriate for 0-5 year olds
4. Support community-based groups in developing neighborhood parks
5. Support coordinated advocacy efforts to address planning issues involving the development of and access to parks and recreational activities for children 0-to-5.
6. Support efforts to educate families with young children about available recreational facilities and activities

Objective I

Improve education and support for early care and education providers

SCFFC APPROACH

1. Sponsor a Training and Education Initiative for early care and education providers, ensuring access to training and education for providers in outlying areas

Objective J

Improve screening, referral and follow-up on referrals for developmental delays

SCFFC APPROACH

1. Support a project to train and encourage CHDP providers and other health care providers to utilize a valid, reliable screening instrument for all children 0-to-5 years old. Project would include referral procedures, ongoing technical assistance and a CHDP provider recertification process
2. Support the development and dissemination of information to parents, CHDP providers and other health care providers regarding stages of healthy child development

Objective K

Decrease the incidence of dental caries in young children

SCFFC APPROACH

1. Support the development and efforts of a Dental Coalition with broad representation from dental care providers, health care providers, early care and education providers, parents/community members and others.

FIRST YEAR EXPENDITURES

We anticipate that by October 2000, Shasta Children and Families First Commission will have received \$3,300,000 in revenues. Our initial estimate is that during our first year of allocations, October 1, 2000 – September 30, 2001, funds may be distributed across strategic focus areas as follows:

Parent Education and Support Services	\$1,592,000	(48%)
Child Care and Early Education	311,500	(10%)
Health and Wellness	736,500	(22%)
Other – Evaluation	330,000	(10%)
Administration	330,000	(10%)
 TOTAL	 \$3,300,000	 (100%)

PLANS FOR REVENUE DISSEMINATION

Shasta Children and Families First Commission will use a variety of allocation vehicles, including mini-grants, short-term project awards, planning grants followed by implementation support, and contracts for services. It may be possible that the SCFFC becomes a direct provider of service.

Most allocations of funds will be made as individual awards, although block grants may be considered, being awarded only with clearly agreed-upon outcome measures and safeguards.

The Commission will consider the private sector's ability to provide service before turning to the public sector, with the assurance that funds will not be used to supplant existing, publicly- or privately-funded programs.

Proposals submitted for funding will be reviewed by a community advisory committee of readers, which is appointed by the Commission. The advisory committee will read and rank the proposals according to Commission guidelines in a public environment and make recommendations to the Commission. If a Commissioner's agency is one of the proposals being recommended for funding, that Commissioner will abstain from discussion and voting on that specific proposal.

All of our funding relationships will be performance-based and will require agreed-upon procedures for monitoring and evaluating. We will attend closely to contract language to clearly define deliverables, thus ensuring that our desired outcomes are addressed.

"HOW ARE THE CHILDREN?"

OVERVIEW

BACKGROUND

In November of 1998, the citizens of California enacted the Children and Families Act, Proposition 10. This initiative aims to promote, support and improve the development of all children from the prenatal period to five years of age by creating an integrated system of information and services to enhance early childhood development.

The initiative will raise approximately \$700 million annually through an additional tax on tobacco products. Twenty percent of these revenues are overseen by the California Children and Families Commission; the remaining eighty percent is being distributed to commissions established specifically for these purposes in each of the state's fifty-eight counties.

Unlike many funding opportunities, the Children and Families Act has as its focus the support of local decision-making and the development of integrated strategies determined as most appropriate by each county. Each county is responsible for developing a *Strategic Plan* based on input and data reflective of its own community. Funding decisions are made at the local level to best meet local needs and interests.

The Shasta Children and Families First Commission was established in March 1999, through an Ordinance adopted by the Shasta County Board of Supervisors. The Shasta Commission is responsible for the development and implementation of this *Strategic Plan* for the most effective use of the approximately \$2 million in annual revenue being allocated to Shasta County through Proposition 10.

PURPOSE

Current research in brain development clearly indicates that the emotional, physical and intellectual environment that a child is exposed to in the early years of life has a profound impact on how the brain is organized. The experiences a child has with respect to parents and caregivers significantly influences how a child will function in school and later in life.

The above paragraph from the California Children and Families Commission mission statement is the basis of statewide efforts being initiated through Proposition 10. Careful attention to our youngest children and to the experiences they have early in life is a powerful means of preventing later difficulties. With this in mind, the State Commission has identified three long-range outcomes, or *strategic results*, to be considered as local commissions develop plans appropriate to their communities:

1. Improved Family Functioning: Strong Families
2. Improved Child Development: Children Learning and Ready for School
3. Improved Child Health: Healthy Children

It is to these ends that the Shasta Children and Families First Commission presents this *Strategic Plan* for Shasta County. It has been developed as a long-term guide to what we hope becomes a community-wide orientation to enhancing the lives and health of our young children and their families.

STRATEGIC PLANNING PROCESS

The Shasta Children and Families First Commission (SCFFC) began its process of strategic planning by asking several questions. We wanted to know what would characterize a community whose attitudes and behaviors demonstrated a value for early childhood. What would be the condition of our children and families? What would such a community *look like* and how can we best utilize revenues generated by Proposition 10 to move us closer to this image?

To answer these questions and to formulate a plan that would be responsive to the Shasta County community, our strategic planning process consisted of seven components: research; formulation of the SCFFC vision and mission; community assessment; community engagement through focus groups; physician survey; identification of SCFFC goals and objectives; and the development of our strategic directions and approaches by an ad hoc advisory committee.

1. RESEARCH (see Appendix A)

To establish a common framework of information from which to work, the Shasta Commission engaged the Shasta County Public Health Department in the Spring of 1999 to compile and present research on topics and indicators relevant to the healthy development of young children. The research examined issues and effective practices related to family planning, prenatal care, bonding and breastfeeding, early intervention, child care and school readiness. The research also identified the best indicators related to measuring the impact of activities in these areas.

With this data in hand, local experts were asked to identify measures that could indicate how well our community or population was doing with regards to healthy practices in each of these areas of early childhood development. These measures, or *indicators*, identified from research and local expert opinion, were adopted by the Shasta Commission as a means to evaluate local proposals for funding.

2. VISION AND MISSION

Following several months of research and discussion, members of the Shasta Commission identified their mutual interest in contributing to an underlying shift in attitude and social practice which would reflect the value and importance of early childhood development. The Commission concluded that in order to make a significant and lasting difference in the lives of young children, an overall heightening of awareness and appreciation of the critical development occurring in the prenatal-to-five year old period was to be our priority. We directed our focus to enhancing the development of a community in which parents and caregivers, community leaders, service providers and other community members promote the well-being of young children.

OUR VISION

Shasta County is a community that works together to create safe, nurturing environments that allow all young children to learn, play and reach their potential as contributing members of society.

OUR MISSION

The Shasta Children and Families First Commission provides leadership and accountability in promoting community attitudes, practices and resource allocations that support the healthy development of children in the prenatal period to 5 years of life. We strengthen community knowledge of this period and our actions support community-wide systems of integrated prevention and early intervention practices.

3. COMMUNITY ASSESSMENT (see Appendix B)

During the past 3-4 years, many assessments of Shasta County have been conducted by county and state governmental entities as well as by community-based organizations. These assessments have captured data and presented it in ways that provide a comprehensive view of the behaviors, needs and patterns of service utilization of the Shasta County community. Rather than duplicating these efforts, the Shasta Commission decided to utilize the data that was already existing. We reviewed all of these materials, gleaned from them the information pertinent to prenatal and early childhood development, and compiled it into an assessment specific to this special age-group.

4. FOCUS GROUPS (see Appendix C)

While recognizing the importance of measurable data in charting our direction, hearing from parents of young children and from providers who serve them was our priority. We wanted to know how they envision a community in which early childhood development is valued. What currently is working? What could be done to enhance the health and well-being of young children and their parents/caregivers?

Within a seven week period, Commission staff conducted twenty-one focus groups throughout Shasta County. Sixteen of these were with parents of young children, in which 96 parents participated. The remaining five groups allowed us to hear from 92 service providers who work with young children and their families throughout the county.

To hear from a good cross-section of parents, each of our sixteen parent groups represented a particular segment of our community. We arranged groups according to geographic location, income level, age and cultural background. To do so, most groups were arranged through pre-existing groups of parents. This provided us with a higher level of comfort within groups since parents were in familiar settings and with familiar people. We utilized personal letters, fliers, phone calls and newsletter articles to inform parents of meetings and, in the Intermountain Area, also ran paid advertisements in area papers to notify the community of our scheduled group. To make participation in our focus groups more convenient and enjoyable, full meals or refreshments were served, a language interpreter was utilized when needed, child care was provided and transportation was arranged when needed. The following focus groups with parents were conducted:

Couples participating in the **AAUW Serendipity Playgroup**
Parents with children enrolled in the **Anderson Head Start**
Breastfeeding mothers participating in a **Breastfeeding Peer Training Group**
Parents living in the **Burney** area

Grandparents volunteering in the **Foster Grandparents Program**
 Report of input received from parents living in the **Garden Tract**, downtown Redding
 Teen moms in the **Infant-Toddler Center**
 Recently divorced mothers whose young children participate in **Kids' Turn**
 Parents with children enrolled in the **Martin Luther King Preschool**
 Parents of children with special needs participating in **Monte Vista School**
 Parents living in the **Oak Run** area
 Parents/grandparents working with the **Private Industry Council**
 Parents from the Southeast Asian community participating in the **Rother School Even Start Program**
 Parents receiving services through the **Salvation Army**
 Parent living in the **Shasta Lake City** area
 Parents living in the **Shingletown** area

With regards to the five focus groups we conducted with service providers, one such group was with 10 advocates/interpreters who work with parents of young children in the Latino community. A second focus group was with 14 family child care providers and a third was with 20 members of the Family Health Division staff of Shasta County Public Health Department. The remaining two provider groups were multi-disciplinary and included representatives from the medical profession, health care, early care and education, social services, education, mental health and faith-based services. One of these groups, attended by 29 service providers, was held in Redding; the other, attended by 19 service providers, was held in Burney.

5. PHYSICIAN SURVEY (see Appendix D)

We also were interested in knowing how the medical community perceived the health and well-being of children from the prenatal period to 5 years of age and their families. We designed a written survey and worked with the Shasta-Trinity Medical Society in distributing and collecting the survey. Approximately 70 OB/GYN, pediatric and family practice physicians in the central area of Shasta County received the survey. Reminder phone calls were made to physicians whose surveys had not been returned by the due date. In all, nine surveys (approximately 12%) were completed and returned.

6. GOALS AND OBJECTIVES

Having received results from our research, community assessment, focus groups and physician survey, the Shasta Children and Families First Commission held a special session during which it identified its goals and objectives. The Commission then appointed an ad hoc advisory committee to review the goals and objectives and to formulate strategies for their accomplishments. Upon receiving minimal revision from the advisory committee, the Shasta Commission approved the following goals and objectives to guide us over the next three-to-five years.

GOAL ONE

Community understands and values early childhood development and child learning

Strategic Result Areas: Improved Family Functioning; Improved Systems for Families

Objectives --

- A. key decision-makers, legislators, policy-makers, faith-based leaders, community leaders and leaders of foundations are educated about issues related to early childhood development

- B. service providers are educated about issues related to early childhood development
- C. parents and primary caregivers are educated about issues related to early childhood development
- D. employers are educated about issues related to early childhood development and family needs
- E. middle/high school age youth are educated about early childhood development

GOAL TWO

Services and resources are accessible

Strategic Result Area: Improved Systems for Families

Objectives --

- A. community-based groups focused on localized services for children 0-to-5 exist countywide
- B. information clearinghouse is developed
- C. increase access to affordable health care coverage
- D. increase access to quality, affordable early care and education for infants and toddlers, sick children and children during non-traditional work hours
- E. increase number of licensed early care and education providers

GOAL THREE

Policies and funding resources are focused on children age 0-to-5 years old

Strategic Result Area: Improved Systems for Families

Objectives --

- A. community-based groups focused on policies and resources for children 0-to-5 exist countywide
- B. local foundations, governments, businesses and organizations financially support and participate in programs focused on 0-to-5
- C. employment policies/practices that support family needs are implemented

GOAL FOUR

Children and families are safe and children are physically, mentally, emotionally, socially and spiritually healthy and ready to learn

Strategic Result Areas:

Improved Family Functioning; Improved Child Health; Improved Child Development

Objectives --

- A. decrease child abuse, neglect and child experience of family violence
- B. decrease parental and family substance abuse and tobacco use, especially during the prenatal to 5 year old period
- C. increase duration of breastfeeding
- D. decrease rates of childhood anemia and obesity
- E. decrease rate/severity of maternal depression
- F. improve identification, assessment and intervention services for young children at risk of impaired attachment
- G. improve language acquisition and family literacy
- H. increase the number and use of parks and recreational activities
- I. improve education and support for early care and education providers (including license-exempt providers)
- J. improve screening, referral and follow-up on referrals for developmental delays
- K. decrease the incidence of dental caries in young children

7. AD HOC STRATEGIC ADVISORY COMMITTEE

As mentioned above, having identified the Shasta Commission's goals and objectives, an ad hoc advisory committee was selected to formulate recommendations of strategies for accomplishing the Commission's goals. The parameters of the committee's work were to aim for attitudinal and behavioral community change, to seek integration of services, to incorporate the work of collaboratives and networks of community members and to stay focused on strategies for prevention and early intervention.

The committee also was charged with clarifying the results we could expect from our efforts and to expand upon the indicators we could use for measuring our progress in meeting our objectives.

The committee, consisting of parents of young children, persons interested in and informed about early childhood, and providers who serve young children and their families represented a cross-section of the community -- geographically, professionally and culturally. Members were selected based on their special areas of expertise, their breadth of knowledge of the Shasta County community and their recognized ability to see *the big picture*.

Through a combination of individual efforts, work done in the large group and in small task groups, the ad hoc strategic advisory committee designed a long-range plan to address the goals and objectives of the Shasta Children and Families First Commission. Committee members formulated strategies directed toward systems change, capacity-building, parent education and support, public education, provider education and support, direct services and community development activities. These *strategic directions* will lead us to the accomplishment of each of our objectives.

The committee then formulated methods the Shasta Commission could implement and support that will allow the specific strategies to be carried out. These methods, or *SCFFC Approaches*, provide the structure through which the Shasta Commission will conduct its work over the next one-to-five years.

Upon identifying the strategies and approaches for each objective, a task group within the advisory committee expanded upon the indicators and expected results previously identified by the Commission.

In all, approximately 440 hours were devoted by committee to these efforts.

AN OBSERVATION OF THE STRATEGIC PLANNING PROCESS

The variety of approaches taken by the Shasta Children and Families First Commission achieved what we had hoped for -- they provided us with a sense of the well-being of our young children and their families and with a clear course to follow in order to enhance this well-being. It should be noted that something else also was achieved by this process. Throughout our numerous gatherings of people -- whether in parent focus groups, provider groups, advisory committee meetings or in our publicly-conducted Commission meetings -- the dialog about the importance of the prenatal-to-five year old period began. Parents have commented on the value of hearing what other parents are experiencing through their conversations in our focus groups.

They have expressed excitement about discussing the importance of their child's development and about having input into shaping our community. Providers have commented that participation in our focus groups and work sessions has lead to new collegial connections and the discovery of new resources that will be of value to the families they serve. The data we collected in our community assessment is already assisting in the work of programs seeking to develop resources for families with young children. Without having yet invested a dime on services or program development, the Shasta Children and Families First Commission is delighted to observe that the inclusiveness of our planning process has already begun to create a community focused on the value and importance young children.

SHASTA COUNTY –AN OVERVIEW

DEMOGRAPHICS

Geography

Nestled between the Cascade Mountains and the Trinity Alps, Shasta County is located at the northern end of the Sacramento Valley, equidistant between San Diego and Seattle on Interstate 5. Majestic Mount Shasta lies to the north and Lassen Volcanic National Park lies to the East. Shasta, Trinity and Whiskeytown Lakes are also within close driving distance. The county covers a total of 3,785 miles

Redding, bisected by the Sacramento River, is the county seat and serves as the major regional trade and employment center for an area that extends well beyond the county's boundaries. The metropolitan area of Redding constitutes the largest urbanized area and contains the highest proportion of commercial and retail facilities between Sacramento and Medford, Oregon.

Fifty-two percent of the landmass of Shasta County lies in the eastern mountains. The topography of this intermountain region is breathtaking. It's rugged terrain, however, also creates physical and economic difficulties as a place to live due to its climate and geographic isolation. This mountainous eastern area covers 2000 square miles and houses 13,000 people -- 8.6% of the county's total population -- for a population density of 6.8 people per square mile.

Population

According to the 1990 U.S. Census, Shasta County's population is 167,000. The projected population growth rate of the County has been estimated by the State Department of Finance to be 2% a year, which will yield a population of 200,000 by the year 2006. In addition to Redding, there are two other incorporated cities in Shasta County: Anderson to the south with a population of 8,865 and Shasta Lake City to the north, with a population of 9,535. Countywide, there are 12,969 children between the ages of 0-to-5 years old.

The population of Shasta County is distributed across ethnic lines as follows:

African American.	1%
Asian American	4%
European-American	89%
Latin-American	3%
Native American	3%

According to California Department of Health Services, Vital Statistics-Birth Records, 84.4% of the live births in Shasta County in 1996 were to European American mothers; 7.5% were to Latino mothers; 4.1% to were to Native American mothers; 2.9% were to Asian American mothers; and 1% were to African American mothers.

Employment

Shasta County, as well as its neighboring counties, has not yet fully recovered from the decline of the timber and mining industries. Retail sales and the service industry dominate employment in Shasta County. While tourism ranks as one of the area's primary industries and provides a steady stream of outside revenue into the community, the employment base to support this industry is concentrated in part-time, seasonal, low paying service-oriented jobs. These employment factors result in a large proportion of working poor within Shasta County's overall population.

The 1998 annual median income for the Redding metropolitan statistical area, as published by HUD, was \$37,100 for a family of four. In comparison, the national median income for the same size household was \$45,300 and the 1999 estimated median family income for California was \$44,766.

Characteristics of the Shasta County Labor Market			
29%	Services	6%	Construction
22%	Retail trade	4%	Wholesale trade
19%	Government	3%	Finance
8%	Manufacturing	2%	Agriculture
7%	Transportation, Commerce, Utilities		

The largest employers in Shasta County are *Schools*, employing 1,802; *Shasta County Government*, 1,550; *Redding Medical Center*, 1,315; *Mercy Medical Center*, 1,258; and *The City of Redding* with 1,000 employees. Ninety-seven percent of the businesses in Shasta County have fewer than 50 employees and 63.6% have fewer than four.

Historically, Shasta County experiences a year-round unemployment rate which averages one to two percent points higher than the state as a whole. However, according to the State Employment Development Department, Shasta County averaged an unemployment rate in 1999 of 7.3%, in comparison to the State's rate of 4.6%. Most of our non-urban areas continue to experience unemployment rates in excess of 10%.

WHAT THE DATA TELLS US (see Appendix B)

Based on the data we compiled from various community assessments, the following patterns and issues related to the physical and social health of young children in Shasta County emerge.

Prenatal Care

Throughout the 1990's, a significantly higher proportion of pregnant women received prenatal care during the first trimester in Shasta County than in California as a whole. Eight-six percent of Shasta County women receive prenatal care in the first trimester which falls short of the *Healthy People 2000* goal of 90%.

Perinatal and Infant Deaths

On average, Shasta County and California have similar fetal death rates. Shasta County achieved the *Healthy People 2000* goal of no more than 5 fetal deaths per year only during 1991-93; California has not yet achieved this goal. There has been a decline in neonatal mortality in the county, from 4.8 per 1,000 births in 1991-93 to 3.8 in 1995-97. The county has met the *Healthy People 2000* objective of no more than 4.5 neonatal deaths per 1,000 live births every year since 1992.

Low Birth Weight

Between 1995-97, an annual average 5.1% of babies born in Shasta County were classified as being low birth weight. This is slightly lower than the percentage of low birthweight babies recorded statewide (6.1%). The *Healthy People 2000* goal is to reduce to 5% or less the number of women delivering low-weight babies.

Births to Teenage Mothers

In Shasta County, 6.5% of 1997 births were to mothers under the age of 18 years old; this proportion is above the 4.6% record statewide. 16.8% of 1997 births in the county were to mothers under the age of 20, compared to only 11.7% statewide. Repeat births to teens in the county have shown a decreasing trend.

Breastfeeding

Shasta County ranks 5th in the state for mothers who initiate breastfeeding at birth. However, the percentage of mothers who maintain breastfeeding is low. The *Healthy People 2000* goal is to have 50% of mothers continue breastfeeding until their babies are 5-to-6 months old as compared to the Shasta County Maternal Child Adolescent Health goal of increasing to 13% the number of women who continue breastfeeding to this age.

Immunizations

In 1998, 78.8% of Shasta County two year olds were up-to-date for immunizations as compared to 62.9% of two year olds statewide. In 1998, 87.6% of children enrolled in kindergarten had received all of their immunizations as compared to 89.3% of kindergarten children statewide.

Health Insurance Coverage

Shasta Community Health Center estimates that more than 30,000 Shasta County residents (all ages) are without any form of health insurance. A significant factor here is the number of persons who are eligible for coverage but not enrolled in programs: for example, 72.6% of area adults are not familiar with Healthy Families, including 70.5% of those living below poverty level.

Dental Care

The lack of available dental services for young children, particularly those in low income families, is a serious concern. The county experiences an inadequate number of pediatric dentists as well as few dentists who will accept Denti-Cal. The cost of dental care and inadequate insurance have been identified as issues related to poor dental care as has been poor information about the importance of early dental care.

Children with Special Needs

The state average for birth defects is 29.1 per 1,000 births. In 1992, Shasta County was above this average with a rate of 35.9 per 1,000 births. As of April 1999, there were 3,003 children with an IEP or IFSP in Shasta County: 448 were under the age of three, 275 were ages 3-5 years old.

Poverty

Shasta County has the 23rd highest rate of child poverty among California's 58 counties. According to the 1990 census, 27.6% of our children between the ages of 0-to-5 years old live in poverty, as compared to 19% of these young children statewide. Through February 1999, an average of 11% of Shasta County's population was receiving TANF assistance (Temporary Aid to Needy Families). According to the 1990 census, the number of homeless persons in Redding comprised an estimated 0.9% of the City's population with 14% of this figure representing children under the age of 18. The risk of a child living in poverty is greatly increased by having a single mother and over one fourth of Shasta County's children live in a single-parent household.

Maternal Education

In Shasta County in 1992, 65.9% of infants were born to women who had completed twelve years of education or less, similar to the percentage of 64.7% for the State; 9.9% of infants were born to County residents who had completed sixteen or more years of education with 15.6% for California overall.

Mental Health

The League of Women Voters in 1998 found that children six years old and under were in the greatest need of mental health services. Very few programs in the county will see children ages 0- 5 because of an absence of mental health professionals with a background in early childhood.

Family Violence/Child

Information suggests that the rate of child abuse in Shasta County is fluctuating, but does not show a clear increasing or decreasing trend. In 1996 there were 139 referrals for investigation of child abuse and neglect per 100,000 children in Shasta County. For the same year, the California child abuse/neglect referral was a lower 75 per 100,000 children.

Substance Abuse

In 1996 an extensive assessment of health status and public opinion about community health concerns, 66% of respondents identified alcohol abuse as one of the most important risky behaviors in Shasta County. Seventy-three percent of these respondents also identified drug abuse as one of our major high risk behaviors. Overall, in this study, substance abuse ranked

second, only behind issues of family violence, as the most significant health issue in our community. Results of a similar study conducted in 1999 replicated these findings. Currently, the county is experiencing a large concern with regards to methamphetamine use. For example, according to the Drug Endangered Children's Program, Shasta County may have the state's biggest methamphetamine problem. An average of 2 babies born per week in Shasta County in 1997 tested positive for methamphetamine and it is believed that this number may be significantly understated.

Tobacco Use

Smoking rates among northern California pregnant women in 1992 were more than double the statewide rates and double the *Healthy People 2000* national objective. In Northern California counties in 1992, 21% of pregnant women reported smoking during pregnancy, compared with 8.8% of pregnant women statewide.

Early Care and Education

Currently in Shasta County, there are 6,807 children 0-5 with working parents: 3,471 of these children are in care outside the family structure. Shasta County ranks 32 among California's 58 counties in its supply of licensed early care slots. The cost for child care ranges from \$300.00 to \$550.00 per month depending on the child's age and the quality of care provided. For a full time minimum wage worker, care for an infant consumes 49% of income. Sixty-two% of the early care requested is for parents who work outside the home part-time and 21% for workers leaving home after 10 a.m. for swing or night shifts.

Transportation

The primary transportation provider for Shasta County is the Redding Area Bus Authority (RABA) which provides service to the metropolitan Redding area. RABA's hours of operation are limited to 6:30 a.m. to 7:30 p.m. on weekdays and 9:30 to 7:30 on Saturdays with no service on Sundays. Communities outside of the Redding area are without public transportation service.

WHAT OUR PARENTS AND PROVIDERS TELL US (see Appendix C)

Through our focus groups we learned about the needs and interests of community members.

Needs and Interests

- breastfeeding support and information for new mothers
- community-based, conveniently-located services
- early care and education provider support and education
- early care and education services for infants/toddler, sick children, children with special needs and children during non-traditional hours
- increased availability of medical, health and other providers with knowledge of early childhood
- health insurance coverage
- mental health services for mothers, families and young children
- multi-culturally and multi-lingually appropriate services
- parental education on a wide array of parenting topics
- parent support services that are accessible and non-threatening

prenatal education on topics related to healthy pregnancy, child development and postpartum issues
recreational facilities and activities for young children and their families
respite care
training/professional education regarding early childhood
transportation - the lack of adequate transportation was repeatedly identified as a barrier to accessing services for families with young children including services such as childcare, health care and recreational facilities.

Attitudinal Themes

Additionally, participants in our focus groups suggested the promotion of several themes that they thought would be positive and beneficial for the healthy development of young children and strong families

Nurturing and raising healthy children involves the entire community

Good parents ask lots of questions – about lots of things

Male involvement in all aspects of parenting is the norm

Breastfeeding is the norm

Parenthood is an important, prized and exciting job

Play is the “work” of children

Cultural diversity is appreciated and beneficial in the community

A child with a special need is “just a typical kid”

<p>-- GOALS AND OBJECTIVES -- -- STRATEGIES AND APPROACHES -- -- RESULTS AND INDICATORS --</p>
--

What follows on the next several pages are the results of our planning process. We are presenting a comprehensive, long-term plan for enhancing early childhood development in Shasta County . . . a plan that may encompass our focus for the next three, four, or five years. Parts of the plan will be implemented and completed within the next year. Others are seen to require a slower process involving research, planning and training before the program is off the ground and making a difference. We recognize that the work of changing attitudes, behavioral patterns and systems of service delivery takes a long time. To do so, we seek to build on existing community strengths, integrate services and address broad barriers to service accessibility.

BUILDING ON COMMUNITY STRENGTHS

Part of the strength of Shasta County lies in its many formal and informal community networks. Neighborhood associations, service clubs, cultural groups and a wide host of other volunteer associations are at the heart of community connections. Our faith-based community is extensive and plays a significant role in supporting community members and addressing social issues and concerns. Countywide we operate with a broad array of services (see Appendix E) that are provided by non-profit organizations, private entities and public programs. Awareness is directed toward the wise utilization of these resources through coordination and efforts to develop systems of care. Shasta County demonstrates a strong commitment to cooperative and collaborative efforts that pull together various groups toward common ends. The plan presented

here is interested in building upon these strengths of our professional community as well as upon the strengths of our *natural* community – the assets in our neighborhoods and the spirit and vision of the people who live here.

INTEGRATING SERVICES

The plan presented here strives for the integration of services in a variety of ways

1. It relies on the expanded work of collaboratives and networks of providers and parents which will increase the coordination of services
2. It empowers members of the community to develop localized programs, activities and services they identify as important for their own children and families
3. It promotes community-wide policy-making decisions that include considerations of early childhood development
4. It creates linkages across service areas with regards to transportation, child care, and the expansion of culturally and linguistically appropriate services
5. It provides for easy access to information on available services and activities
6. It sets in motion improved systems for coordinated screening, referral and follow-up
7. It provides opportunities for inter-disciplinary training of providers on a large range of topics related to early childhood
8. It provides for the integration of the private and public sectors of the community with regards to family-friendly practices
9. For the sake of efficiency, the information campaigns to address objectives throughout the plan will combine with one another, thus integrating the various topics and issues related to early childhood into one common theme
10. Integrated data collection systems and protocols will be established as part of our evaluation plan
11. It relies upon the formation of new partnerships for the sharing of financial and non-monetary resources

ADDRESSING BROAD BARRIERS TO SERVICE ACCESSIBILITY

Inadequate transportation was identified throughout our focus groups and in community assessments as a barrier to, among other things, prenatal care, child health care, early care and education, employment, family recreation and parental support. Our strategy for addressing the issue of transportation is to have it considered in every segment of the plan in which physical access is required. As such, every program we support will be required to provide transportation or have other ways of ensuring access. We will encourage and support the coordination of transportation services among providers. We also will continue to consider other ways of developing expanded transportation resources.

Lack of child care connected with parent education programs, treatment services and other activities also has been identified as a barrier to participation. All programs receiving our support will be required to address the issue of child care. We will support the linkage between our program providers and local early care services to ensure not only the availability of care but the utilization of quality care. We also will encourage and support the coordination of child care efforts among our program providers.

To be accessible for all parents of young children in Shasta County, services need to be available in multiple languages and in ways that are sensitive to differences in cultural practice. All programs and services receiving our support will have to ensure linguistic and cultural appropriateness.

DEFINITIONS OF TERMS IN THE SCFFC STRATEGIC PLAN

Goals and Objectives are what we are trying to achieve:

Goals – Broad statements describing the Commission’s long-term visions for desired change

Objectives – Specific descriptions of a desired change that is short-range and measurable. Accomplishing our objectives supports the eventual achievement of our long-range goals.

Strategic Directions and SCFFC Approaches are what we intend to do and how we intend go about doing it.

Strategic Directions – Strategies aimed at: systems change; capacity-building; parent education and support; public education; provider education and support; direct services; and community development. The implementation of these strategies over time will lead us to the accomplishment of our objectives.

SCFFC Approaches – These are the methods we will use to carry out the strategies. In some cases, the SCFFC Approach represents a beginning step we will take; in others it indicates a type of program we seek to develop which will address the strategies identified; in still others it defines our support for the formation of a group or collaborative to plan the implementation of the identified strategies. These SCFFC Approaches will be the basis of our resource allocations.

Results and Indicators are related to how we evaluate the effectiveness of our efforts

Expected Results – Observable changes that we can expect to happen if our strategies for each objective are effective over time. *Results* are not directly measurable but are the outcomes of the efforts we direct toward accomplishing our objectives. They may be noticeable in changed behaviors and general signs of well-being.

Sample Indicators – Specific data-based measures that will let us know if we are making progress in achieving our objectives.

GOAL I. COMMUNITY UNDERSTANDS AND VALUES EARLY CHILDHOOD DEVELOPMENT AND CHILD LEARNING STRATEGIC RESULT AREAS: IMPROVED FAMILY FUNCTIONING IMPROVED SYSTEMS FOR FAMILIES		
<u>OBJECTIVE</u>	<u>STRATEGIC DIRECTIONS</u>	<u>SCFFC APPROACH</u>
A. KEY DECISION-MAKERS, LEGISLATORS, POLICY-MAKERS, FAITH-BASED LEADERS, COMMUNITY LEADERS AND LEADERS OF FOUNDATIONS ARE EDUCATED ABOUT ISSUES RELATED TO EARLY CHILDHOOD DEVELOPMENT AND LEARNING	Education <i>could include</i> but not be limited to: brain development; attachment; the connection between early child development and quality childcare experiences; the important role of family literacy to language acquisition and early child development and learning; the value of family recreation	<ol style="list-style-type: none"> 1. Develop a public awareness and education campaign, utilizing various approaches and forms of media 2. Research and develop materials/references regarding the important issues/factors involved in early childhood development and child learning 3. Develop a professional training and education project to: <ol style="list-style-type: none"> a. identify and coordinate professional training and education resources b. assess professional interests and educational needs c. develop appropriate training/education plans, including the support of professional involvement in professional education opportunities d. arrange for professional conferences, educational sessions, seminars, in-house staff training programs, etc. e. evaluate training and educational offerings 4. Offer community-based workshops, employer seminars, public education workshops, programs and events including programs designed for middle/high school aged youth 5. Offer training(s) and follow-up activities related to infant-to-5 year old <i>developmental assets</i> (e.g. Search Institute) 6. Support coordinated advocacy efforts to educate decision-makers, legislators, policy-makers & leaders regarding the impact of decisions on the 0-5 population
B. SERVICE PROVIDERS ARE EDUCATED ABOUT ISSUES RELATED TO EARLY CHILDHOOD DEVELOPMENT AND LEARNING	Education <i>could include</i> but not be limited to: brain development; attachment; the process of infant/parent attachment and its importance to the healthy development of children; the value of breastfeeding to healthy child development; the link between maternal mental health, attachment and healthy child development; early identification and intervention of developmental delays; the value of family recreation; the effects of drugs, alcohol and tobacco on the healthy development of young childhood; the connection between early child development and quality childcare experiences	
C. PARENTS AND PRIMARY CAREGIVERS ARE EDUCATED ABOUT ISSUES RELATED TO EARLY CHILDHOOD DEVELOPMENT AND LEARNING	Education <i>could include</i> but not be limited to: brain development; attachment and its link to health; ages and stages of development; age-appropriate child behavior and development; the value of breastfeeding in relation to child development & attachment; the recognition and arrangement of quality childcare; maternal mental health and its effects on infant/parent relationships; the connection between early child development and quality childcare experiences; the important role of family literacy to language acquisition; the value of family recreation; the effects of drugs, alcohol and tobacco on healthy childhood development	
D. EMPLOYERS ARE EDUCATED ABOUT ISSUES RELATED TO EARLY CHILDHOOD DEVELOPMENT AND FAMILY NEEDS	Education <i>could include</i> but not be limited to: the importance of breastfeeding to infant/parent attachment and to healthy early childhood development; the connection between early child development and quality childcare experiences; the important role of family literacy to language acquisition, early childhood development and learning	
E. MIDDLE/HIGH SCHOOL AGE YOUTH ARE EDUCATED ABOUT EARLY CHILDHOOD DEVELOPMENT	Education <i>could include</i> but not be limited to: brain development; attachment; ages and stages of development; the important role of breastfeeding in early childhood development and attachment; the importance of nutrition and activity to early childhood development; the effects of drugs, alcohol and tobacco on healthy childhood development	

EXPECTED RESULTS –

1. Community leaders give priority to factors significant to early childhood development and learning in their decision-making
2. Parents are knowledgeable about early childhood development and practice healthy, nurturing and effective parenting behaviors
3. Employers recognize the importance and efficiency of considering the well-being of families with young children in determining workplace policies and procedures
4. Adolescents have a realistic picture of what is involved in parenting and raising healthy young children
5. Community attitudes and behaviors reflect the importance of early childhood development and learning
6. Community members take action to support child, family and community well-being

SAMPLE INDICATORS –

1. Increase in community dialog regarding issues related to young children and families
2. Increase in parent education and support opportunities available
3. Increase in the number of parents/primary caregivers who access educational and support opportunities.
4. Increase in the number of health care professionals, parent educators, early care providers and others providers who are trained in infant brain development research and its relationship to parenting
5. Improved results on surveys of developmental assets (e.g.: SEARCH Institute)
6. Increased number of employers who support family-friendly employment practices

GOAL II. SERVICES AND RESOURCES ARE ACCESSIBLE***STRATEGIC RESULT AREA: IMPROVED SYSTEMS FOR FAMILIES***

<u>OBJECTIVE</u>	<u>STRATEGIC DIRECTIONS</u>	<u>SCFFC APPROACH</u>
A. COMMUNITY-BASED PLANNING GROUPS FOCUSED ON LOCALIZED SERVICES FOR CHILDREN AGED 0-TO-5 EXIST COUNTYWIDE	<ol style="list-style-type: none"> 1. CAPACITY-BUILDING <ol style="list-style-type: none"> a. familiarize community members with neighborhood-based approaches to service development b. identify leaders, assets and needs within self-defined communities/neighborhoods c. encourage development of skills and processes for community-based planning 2. SERVICES Community members will be involved actively in determining, developing and/or participating in the offering of services within their communities. These services could include, but are not limited to, family literacy activities; transportation; availability of early care and education services; development of parks & recreational activities; activities aimed at the prevention and early intervention of family violence, substance abuse and/or tobacco use; support regarding maternal depression 	<ol style="list-style-type: none"> 1. Sponsor <i>community-building workshop(s)</i> (e.g. McKnight's, <i>Building Communities from the Inside Out</i>) including parents with children 0-5, business representatives and civic leaders. 2. Support pilot community-based projects utilizing community collaboratives and/or community-based partnerships 3. Ensure that SCFFC-sponsored collaboratives, partnerships and planning groups include an empowering number of parents of young children

EXPECTED RESULTS –

1. Localized community groups address their self-defined needs and interests with regards to early childhood
2. Children and families have access to community-based services and activities

SAMPLE INDICATORS –

1. Number of parents/caregivers participating in formal and informal community planning activities
2. Number of parents emerging as leaders at the localized community level
3. Number of agencies and community groups collaborating to provide localized services
4. Number of community-based services and activities available
5. Number of families accessing projects initiated by community-based planning groups

<u>OBJECTIVE</u>	<u>STRATEGIC DIRECTIONS</u>	<u>SCFFC APPROACH</u>
B. <i>INFORMATION CLEARINGHOUSE IS DEVELOPED</i>	<ol style="list-style-type: none"> 1. SERVICES <ol style="list-style-type: none"> a. develop and promote use of a toll-free telephone referral line for families with children prenatal to 5 years of age with updated information on services; recreational, educational and cultural activities; parent education resources; etc. b. develop and promote use of an information website relevant for families with children prenatal to 5 years of age 	<ol style="list-style-type: none"> 1. Support the development and coordination of a referral information telephone line and website for families with children prenatal to 5 years old
EXPECTED RESULTS – <ol style="list-style-type: none"> 1. Parents/providers are informed about and access services and resources related to the prenatal to 5 year old period SAMPLE INDICATORS – <ol style="list-style-type: none"> 1. Increased number of parents and service providers who know what services are available and have the information necessary to access/refer to those services 2. Increased number of pregnant parents and children age 0-to-5 being served by community resources 		

<u>OBJECTIVE</u>	<u>STRATEGIC DIRECTIONS</u>	<u>SCFFC APPROACH</u>
C. <i>INCREASE ACCESS TO AFFORDABLE HEALTH CARE COVERAGE</i>	<ol style="list-style-type: none"> 1. SYSTEMS <ol style="list-style-type: none"> a. develop network of Healthy Families Enrollment Entities b. include routine inquiries regarding health care coverage and coverage options during intake interviews across service systems 2. PROVIDER EDUCATION <ol style="list-style-type: none"> a. update Healthy Families Enrollment Entities regarding changes in eligibility and enrollment criteria, regulations and procedures for MediCal for Children/Pregnant Women, Healthy Families, AIM and other health coverage options b. educate Healthy Families Enrollment Entities regarding resources and referrals to other providers and services 3. PUBLIC EDUCATION <ol style="list-style-type: none"> a. increase public awareness of Healthy Families Program and other options for health care coverage 	<ol style="list-style-type: none"> 1. Provide support for the coordination and collaboration of Healthy Families Enrollment Entities throughout Shasta County 2. Support a public awareness campaign regarding health coverage options

EXPECTED RESULTS –

1. Eligible children and pregnant mothers are enrolled in Healthy Families, Medi-Cal, AIM and/or other programs available for health coverage

SAMPLE INDICATORS –

1. Increased percentage of income eligible children and pregnant mothers enrolled in Healthy Families, Medi-Cal, AIM and/or other programs available for health coverage

<u>OBJECTIVE</u>	<u>STRATEGIC DIRECTIONS</u>	<u>SCFFC APPROACH</u>
D. <i>INCREASE ACCESS TO QUALITY, AFFORDABLE EARLY CARE AND EDUCATION FOR INFANTS AND TODDLERS, SICK CHILDREN, CHILDREN WITH SPECIAL NEEDS AND CHILDREN DURING NON-TRADITIONAL WORK HOURS</i>	<ol style="list-style-type: none"> 1. SYSTEMS <ol style="list-style-type: none"> a. implement a centralized child care eligibility list with one-point of entry for parents and providers b. develop a managed network of substitute providers, including a focus on in-home care for sick children 2. CAPACITY-BUILDING <ol style="list-style-type: none"> a. develop community-based child care co-ops, including care options during non-traditional hours b. develop incentives for early care and education providers to serve infants/toddlers, children with special needs and children during non-traditional hours 	<ol style="list-style-type: none"> 1. Support the design of a countywide centralized child care eligibility list 2. Support the development of neighborhood-based child care co-ops 3. Support development of a managed network of substitute providers of early care and education services 4. Develop effective incentives for early care and education providers

EXPECTED RESULTS –

1. Families with infants and toddlers and/or with children who have special needs, have access to quality, affordable early care and education services
2. Parents who work non-traditional hours and/or have sick children are able to go to work because their children are well cared for
3. Families have one point of entry into early care and education services

SAMPLE INDICATORS –

1. Increase in the number of early care and education spaces for children age 0-5 in families with non-traditional work hours
2. Increase in the number of providers of early care and education services who will care for sick children
3. Increase in the number of available licensed early care and education spaces available for infants and toddlers
4. Increased percentage of children with developmental delays and other special needs who have access to qualified early care and education programs
5. Number of families accessing early care and education through a coordinated, centralized service

<u>OBJECTIVE</u>	<u>STRATEGIC DIRECTIONS</u>	<u>SCFFC APPROACH</u>
E. <i>INCREASE NUMBER OF LICENSED EARLY CARE AND EDUCATION PROVIDERS</i>	<ol style="list-style-type: none"> 1. SYSTEMS/PROVIDER SUPPORT AND CAPACITY-BUILDING <ol style="list-style-type: none"> a. develop a managed network of substitute providers to offer relief for family child-care providers and center based providers 2. CAPACITY-BUILDING <ol style="list-style-type: none"> a. develop incentives to attract and retain early care and education providers 	<ol style="list-style-type: none"> 1. Support development of a managed network of substitute providers of early care and education services 2. Develop effective incentives for early care and education providers

EXPECTED RESULT –

1. Parents and children have access to licensed early care and education providers

SAMPLE INDICATORS –

1. Increase in the average number of years of experience working in early care and education per provider
2. Decreased percentage of caregivers who leave the early care and education profession in a 12-month period
3. Increase in the number of spaces in accredited family child care homes and early care and education centers
4. Increase in the number of unlicensed providers who become licensed

Goal III. POLICIES AND FUNDING RESOURCES ARE FOCUSED ON CHILDREN 0-to-5 YEARS OLD**STRATEGIC RESULT AREA: IMPROVED SYSTEMS FOR FAMILIES**

<u>OBJECTIVE</u>	<u>STRATEGIC DIRECTIONS</u>	<u>SCFFC APPROACH</u>
A. <i>COMMUNITY-BASED PLANNING GROUPS FOCUSED ON POLICES AND RESOURCES FOR CHILDREN AGE 0-TO-5 EXIST COUNTYWIDE</i>	<ol style="list-style-type: none"> 1. CAPACITY-BUILDING <ol style="list-style-type: none"> a. identify leaders, assets and needs within self-defined communities/neighborhoods b. encourage development of skills and processes for community-based planning c. educate community members to develop and research/secure resources for families with prenatal to 5 year old children d. advocate for the allocation of local, state and federal resources e. develop visions of each self-defined community 	<ol style="list-style-type: none"> 1. Sponsor <i>community-building workshop(s)</i> (e.g. McKnight's, <i>Building Communities from the Inside Out</i>) including parents with children 0-5, business representatives and civic leaders. 2. Support the development of community-based policy and funding groups 3. Provide technical assistance regarding resource identification and development
EXPECTED RESULT – <ol style="list-style-type: none"> 1. Members of localized community groups participate in policy-making activities and advocate for the needs and interests of prenatal to 5 year old children SAMPLE INDICATORS – <ol style="list-style-type: none"> 1. Number of policy/funding decisions influenced by localized community planning groups 2. Number of community groups involved in policy-making and resource development activities related to young children 		

<u>OBJECTIVE</u>	<u>STRATEGIC DIRECTIONS</u>	<u>SCFFC APPROACH</u>
B. <i>LOCAL FOUNDATIONS, BUSINESSES, GOVERNMENTS AND ORGANIZATIONS FINANCIALLY SUPPORT AND PARTICIPATE IN PROGRAMS FOCUSED ON 0-TO-5 YEAR OLDS</i>	<ol style="list-style-type: none"> 1. Encourage local foundations, businesses and organizations to collaborate in support of an initiative focused on 0-5 2. Research and develop local community resources that have the potential to support programs for 0-5 through funding, collaboration, advising, initiatives, advocacy, facilitation and in-kind donations 3. Conduct ongoing research and pursue non-local funding and resource opportunities that focus on 0-5 4. Coordinate and write grant applications for available, local and non-local funding opportunities for 0-5 	<ol style="list-style-type: none"> 1. Support resource development efforts aimed at the development of funding and resource opportunities

EXPECTED RESULT –

1. Joint planning efforts are directed to early childhood
2. Joint funding allocations are directed to early childhood

SAMPLE INDICATORS –

1. Level of pooled resources directed to early childhood issues
2. Level of coordinated planning efforts to address early childhood issues

<u>OBJECTIVE</u>	<u>STRATEGIC DIRECTIONS</u>	<u>SCFFC APPROACH</u>
C. EMPLOYMENT POLICIES/PRACTICES THAT SUPPORT FAMILY NEEDS ARE IMPLEMENTED	<ol style="list-style-type: none"> 1. SYSTEMS <ol style="list-style-type: none"> a. establish employer participation partnerships among large employers, small companies, associations/manufacturers, and/or employer aggregates 2. CAPACITY-BUILDING <ol style="list-style-type: none"> a. create research-based data regarding i) the economic role of the prenatal through early childhood service industry; ii) the benefits to private businesses and the business community of addressing family-related needs 3. EMPLOYER EDUCATION/SUPPORT <ol style="list-style-type: none"> a. provide employers with information about the benefits of family-friendly policies and practices including reduced absenteeism, maintenance of and potential increase in production, reduction of turnover and loss of trained personnel, enhanced employee longevity, earlier return from family leave, benefits to the employer/customer relationship of family-friendly practices b. information clearinghouse including information of employer successes c. provide education, ideas and resources/referrals to employers on how to implement family-friendly practices, including but not limited to worksite-based or centrally-located child care facilities; flexible work schedules; telecommuting/at-home work; job-sharing; in-house referral system for emergency situations; babysitting coops; nursing/pumping nooks; support for language acquisition and family literacy d. develop “family-friendly employer” recognition/awards program 	<ol style="list-style-type: none"> 1. Support the utilization of an <i>Employer Liaison</i> to work with the employer community to engage, educate and develop participation opportunities for employers or employer groups 2. Develop pilot project(s) with large, small and/or aggregates of employers

EXPECTED RESULT –

1. Employers create employment policies and procedures that address the well-being of young children and their families

SAMPLE INDICATORS –

1. Increase in the percentage of breastfeeding women whose employers accommodate for breastfeeding
2. Increase in the number of businesses that offer parental leave for child-centered needs
3. Increase in the percentage of parents of children 0-to-5 years old who have access to childcare at or near the worksite

GOAL IV. CHILDREN AND FAMILIES ARE SAFE AND CHILDREN ARE PHYSICALLY, MENTALLY, EMOTIONALLY, SOCIALLY AND SPIRITUALLY HEALTHY AND READY TO LEARN STRATEGIC RESULT AREAS: IMPROVED FAMILY FUNCTIONING IMPROVED CHILD HEALTH IMPROVED CHILD DEVELOPMENT		
<u>OBJECTIVE</u>	<u>STRATEGIC DIRECTIONS</u>	<u>SCFFC APPROACH</u>
A. DECREASE CHILD ABUSE, NEGLECT AND CHILD EXPERIENCE OF FAMILY VIOLENCE	<ol style="list-style-type: none"> 1. SYSTEMS – Coordination of Services <ol style="list-style-type: none"> a. develop regional collaborative, community-based partnerships and coordinated services for prevention and early intervention b. develop increased capacity to identify and intervene in the early stages of family issues c. increase routine screening of women for substance abuse throughout pregnancy 2. PARENT SUPPORT AND EDUCATION <ol style="list-style-type: none"> a. offer family education regarding communication skills, conflict management, stress management and healthy, respectful family relationships b. provide parent telephone support line c. offer opportunities for parent-to-parent support within neighborhoods d. provide home visiting services, with “no strings attached” e. recognize and address the interrelationships among substance abuse, domestic violence, child abuse and psycho-social development 3. PROVIDER EDUCATION/TRAINING <ol style="list-style-type: none"> a. recognize and address the interrelationships among substance abuse, domestic violence, child abuse and psycho-social development b. provide education to public service agencies c. provide training for staff in programs serving 0-5 year olds about substance abuse and related interventions 4. PUBLIC EDUCATION <ol style="list-style-type: none"> a. educate the public to recognize and address the interrelationships among substance abuse, domestic violence, child abuse and animal abuse b. provide public education about child abuse and neglect to parents and children through 12th grade 5. SERVICES <ol style="list-style-type: none"> a. provide respite care in healthy environments for primary caregivers b. offer family counseling regarding domestic violence, child abuse and substance abuse c. develop residential shelter from violence in Intermountain Area d. ensure availability of quality child care & transportation related to services e. ensure linguistically/culturally-appropriate services 	<ol style="list-style-type: none"> 1. Support development of regional and community-based collaborative(s) focused on prevention, identification and early intervention of child abuse, neglect and child experience of family violence. 2. Support development of parental support telephone line. 3. Support development of respite care.

EXPECTED RESULTS –

1. Children age 0-to-5 years old are nurtured in homes free of violence

SAMPLE INDICATORS –

1. Reduced number of substantiated cases of child abuse
2. Decrease in the percentage of CPS reports that are repeat referrals
3. Decrease in the number of domestic violence reports involving young children
4. Increase in the number of persons that parents of infants can call upon for help
5. Number of persons served through the parent support line
6. Number of persons receiving respite services
7. Increase in the percentage of children ages 0-to-5 who have at least one parent or primary caregiver who demonstrates non-abusive disciplinary methods
8. Decrease in the average score by parents of infants on the Child Abuse Potential Inventory

<u>OBJECTIVE</u>	<u>STRATEGIC DIRECTIONS</u>	<u>SCFFC APPROACH</u>
B. <i>DECREASE PARENTAL AND FAMILY SUBSTANCE ABUSE AND TOBACCO USE, ESPECIALLY DURING THE PRENATAL TO 5 YEAR OLD PERIOD</i>	<ol style="list-style-type: none"> 1. SYSTEMS <ol style="list-style-type: none"> a. improve coordination and communication among agencies and faith-based providers to leverage resources, clarify prevention/early intervention/treatment strategies and identify gaps in existing services b. increase screening of pregnant women in health care settings 2. PARENT SUPPORT AND EDUCATION <ol style="list-style-type: none"> a. make more parenting support and education programs available, including information about: substance abuse; tobacco use and second hand smoke; effects of use on fetus; breastfeeding and tobacco and substance abuse b. offer more support during and after pregnancy (build a “community nest” for new families) c. provide in-home family assessments and support d. increase emphasis by health care providers on the fetal effects of tobacco use 3. PUBLIC EDUCATION <ol style="list-style-type: none"> a. educate the public about the correlation between the use of tobacco, alcohol and other drugs and unwanted pregnancy, child abuse, neglect, child development and duration of breastfeeding b. develop media awareness campaign to address effects of tobacco, drugs and alcohol on the fetus and first 5 years of life (using an approach that dispels stigma and prejudices and promotes hope for success in abstinence and healthy child development) c. educate the community that substance abuse and tobacco use are community problems which require everyone’s involvement and help 4. SERVICES <ol style="list-style-type: none"> a. develop community family centers that support sobriety and healthy family activities b. offer drug, alcohol and tobacco education and prevention activities 	<ol style="list-style-type: none"> 1. Support a collaborative effort of agency and faith-based providers of prevention and early intervention services to develop community family centers that support sobriety and healthy family activities. 2. Support public education campaign(s) regarding substance abuse and tobacco use 3. Support parent education and support for tobacco and substance abuse prevention and cessation 4. Support effort to identify and provide interventions for substance abusing and smoking parents during pregnancy and perinatal period

	<ul style="list-style-type: none"> c. offer tobacco cessation programs, including peer support and education d. offer peer support and education to discontinue use of alcohol and drugs. e. provide referrals and access to supportive services, including those for single parents f. offer and promote local parenting programs that support positive parent/child involvement g. provide respite care and parental relief h. ensure access to programs, through transportation or other means, and quality child care (planned in conjunction with early care services) i. offer availability of programs during evenings and weekends j. offer programs that are culturally and linguistically appropriate 	
<p>EXPECTED RESULTS –</p> <ul style="list-style-type: none"> 1. Young children are born into and raised in smoke-free environments 2. Young children are born into and raised in environments in which drugs and alcohol are not abused. <p>SAMPLE INDICATORS –</p> <ul style="list-style-type: none"> 1. Decrease in the percentage of all infants exposed to tobacco during pregnancy 2. Decrease in the percentage of drug-exposed infants 3. Decrease in the percentage of children age 0-to-5 who have at least 1 parent/primary caregiver who has used illicit drugs and/or has had 5 or more alcoholic drinks within 1 day during the past month 4. Decrease in the percentage of children ages 0-to-5 who are exposed to second-hand smoke in their homes 5. Increase in the percentage of smoking or substance abusing women/primary caregivers accessing smoking cessation, substance/alcohol abuse treatment services 		

<u>OBJECTIVE</u>	<u>STRATEGIC DIRECTIONS</u>	<u>SCFFC APPROACH</u>
C. INCREASE DURATION OF BREASTFEEDING	<ul style="list-style-type: none"> 1. SYSTEMS <ul style="list-style-type: none"> a. develop a resource center to increase the capacity of women to effectively breastfeed, including satellite center(s) in outlying area(s) 2. CAPACITY-BUILDING <ul style="list-style-type: none"> a. increase availability of lactation consultants (including bilingual consultants) 3. PARENT SUPPORT AND EDUCATION <ul style="list-style-type: none"> a. provide follow-up services and 24-hour on-call support during early postpartum period b. include breastfeeding information in prenatal classes c. educate women regarding the benefits and mechanics of breastfeeding d. address women's embarrassment and lack of self-confidence regarding breastfeeding e. address the importance of support for breastfeeding by peers and family members f. provide outreach to new mothers g. provide education about the benefits of breastfeeding 4. PROVIDER EDUCATION/TRAINING <ul style="list-style-type: none"> a. provide education to transform medical providers into allies of 	<ul style="list-style-type: none"> 1. Develop a breastfeeding resource program with satellite site(s) in outlying area(s).

	<p>breastfeeding mothers who want to solve breastfeeding problems instead of quitting</p> <p>b. promote the development of baby-friendly hospitals</p> <p>i. lists of breastfeeding support phone numbers</p> <p>ii. networks for nursing mothers</p> <p>iii. distribute wellness kits without formula at discharge</p> <p>c. work with Mercy Family Practice Residency Program and Shasta College Nursing Program to educate providers regarding breastfeeding</p> <p>5. PUBLIC EDUCATION</p> <p>a. develop media campaign to increase social support for breastfeeding and to increase acceptance of public breastfeeding</p> <p>b. address the importance of support for breastfeeding by peers and family members (especially by male partners)</p> <p>c. provide education about the benefits of breastfeeding</p> <p>6. SERVICES</p> <p>a. increase availability of breast pumps</p> <p>b. ensure access to program through transportation or other arrangements and quality child care</p> <p>c. services delivered through linguistically and culturally appropriate means</p> <p>7. COMMUNITY DEVELOPMENT EFFORTS</p> <p>a. promote employer/school/business support of breastfeeding</p> <p>b. provide incentives for employer support of breastfeeding</p> <p>c. promote baby-friendly restaurants</p> <p>d. develop breastfeeding gardens at public events/festivals</p>	
<p>EXPECTED RESULT –</p> <p>1. New mothers breastfeed their infants until at least 6 months of age</p> <p>SAMPLE INDICATORS –</p> <p>1. Increase in the percentage of women who initiate breastfeeding</p> <p>2. Increase in the percentage of women who breastfeed their infants until 6 months of age</p> <p>3. Increase in the percentage of women who breastfeed their infants until 1-year of age</p> <p>4. Increase in the percentage of women whose most significant social support person is supportive of breastfeeding</p> <p>5. Increase in the percentage of women who are served by a lactation counselor</p>		

<u>OBJECTIVE</u>	<u>STRATEGIC DIRECTIONS</u>	<u>SCFFC APPROACH</u>
<p>D.</p> <p>DECREASE RATES OF CHILDHOOD ANEMIA AND OBESITY</p>	<p>1. SYSTEMS</p> <p>a. promote universal screening for anemia and childhood obesity with appropriate intervention and referral to nutrition services</p> <p>b. address nutritional culturally appropriate food choices and physical activity in early care and education programs</p> <p>2. CAPACITY-BUILDING</p> <p>a. increase availability of nutritionists who specialize in childhood obesity/nutrition</p>	<p>1. Support professional education and the development of appropriate intervention materials for use by registered dietitians, MDs and early care and education providers regarding early childhood anemia and obesity</p> <p>2. Support community-based organizations to develop and offer nutritional education</p>

	<p>3. PARENT SUPPORT/EDUCATION</p> <ul style="list-style-type: none"> a. provide nutrition education for parents and children in early care and education programs b. provide parent education regarding stages of child development and related food choices, quantities and eating strategies c. educate parents and caregivers to make healthier food choices d. provide education on the signs and symptoms of anemia e. provide education regarding absorption of iron and vitamin C <p>4. PROVIDER EDUCATION/TRAINING</p> <ul style="list-style-type: none"> a. develop interventions to address preschool-age obesity b. provide nutrition education to service providers c. incorporate culturally appropriate food choices in early care and education programs d. provide education on the signs and symptoms of anemia e. provide education regarding absorption of iron and vitamin C <p>5. PUBLIC EDUCATION/AWARENESS</p> <ul style="list-style-type: none"> a. develop media campaign to address healthy choices among families in the areas of nutrition and physical activity <ul style="list-style-type: none"> i. promote minimization of television and video games as recreational pastimes ii. confront unhealthy lifestyle/environmental practices iii. counter advertising for sugar snacks and sodas b. prevent lead poisoning through screening and abatement activities <p>6. SERVICES</p> <ul style="list-style-type: none"> a. include physical activities for children (including those with special needs) and families at community events b. provide cooking classes and opportunities to increase food preparation skills c. promote cooking and food preparation classes in high schools 	<p>and physical activity opportunities for families with children 0-5 years old</p> <p>3. Support the development of a public awareness campaign on issues related to early childhood anemia and obesity</p>
<p>EXPECTED RESULT –</p> <ul style="list-style-type: none"> 1. Children entering kindergarten are well-nourished and physically active <p>SAMPLE INDICATORS –</p> <ul style="list-style-type: none"> 1. Decrease in the percentage of children ages 0-to-5 who are overweight 2. Decrease in the percentage of children ages 0-to-5 who are anemic 3. Increase in the knowledge and application of healthy child nutrition and physical activity practices by early care and education providers 4. Increase in the number of parents/primary caregivers who access nutrition education and services 5. Increase in community offerings of affordable and accessible activities that promote physical activity for families with young children 6. Increase in the average number of minutes each day that children in early care and education settings are engaged in physical activity 7. Increase in the number of early care and education providers who are involved in the state nutrition program 8. Decrease in the number of reported cases of children under 5 with blood lead levels exceeding 10ug/dl per 100,000 children 		

<u>OBJECTIVE</u>	<u>STRATEGIC DIRECTIONS</u>	<u>SCFFC APPROACH</u>
E. DECREASE RATE/SEVERITY OF MATERNAL DEPRESSION	1. CAPACITY-BUILDING <ul style="list-style-type: none"> a. develop funding sources for counseling and treatment of maternal depression b. increase ability in the private sector to identify/diagnose maternal depression 2. PUBLIC & PROVIDER EDUCATION AND SUPPORT <ul style="list-style-type: none"> a. educate mothers about postpartum depression and provide appropriate referrals b. educate providers about maternal depression and resources available c. educate the public about the impact of maternal depression on attachment and early brain development 3. SERVICES <ul style="list-style-type: none"> a. develop treatment options for poor/underinsured women b. develop referral list/resource guide for service providers 	Fund development of a Mental Health Initiative for prenatal to 5 years old, with emphasis on 0-3. Focus on: <ul style="list-style-type: none"> 1. decreasing rate and severity of maternal depression 2. identification, assessment and intervention services for young children at-risk of impaired attachment. <ul style="list-style-type: none"> a. include focus on reattachment issues b. encourage and foster the father/child bond c. identification of pregnant mothers at risk of poor attachment
<p>EXPECTED RESULT –</p> <ul style="list-style-type: none"> 1. Maternal depression that is problematic to attachment occurs less frequently and persists for periods of shorter duration <p>SAMPLE INDICATORS –</p> <ul style="list-style-type: none"> 1. Increase in the number of primary care and maternal health staff trained to identify maternal depression 2. Increase in the percentage of pregnant women who receive education about postpartum depression and services available 3. Increased percentage of women screened for postpartum depression at their 6-week post-birth physical exam 4. Increase in the percentage of women who report improved functioning as a result of treatment for maternal depression 		

<u>OBJECTIVE</u>	<u>STRATEGIC DIRECTIONS</u>	<u>SCFFC APPROACH</u>
F. IMPROVE IDENTIFICATION, ASSESSMENT AND INTERVENTION SERVICES FOR YOUNG CHILDREN AT RISK OF IMPAIRED ATTACHMENT	1. SYSTEMS <ul style="list-style-type: none"> a. develop a program focused on attachment assessment and intervention b. incorporate screening of attachment and children's social-emotional situations when assessing parents/families for other mental health and social services programs 2. CAPACITY-BUILDING <ul style="list-style-type: none"> a. increase availability of providers who are knowledgeable about 0-3 year old mental health and psycho-social development b. develop specific intervention plans that address the etiology of problems related to identified attachment disorder c. research and adopt screening and assessment tools related to attachment d. increase number of providers who assess attachment in a standardized way 3. PARENT SUPPORT AND EDUCATION <ul style="list-style-type: none"> a. provide home-base services 4. PROVIDER EDUCATION AND TRAINING <ul style="list-style-type: none"> a. provide training for service providers and others who come into contact with young children and families regarding identification of families at risk of poor attachment 	Fund development of a Mental Health Initiative for prenatal to 5 years old, with emphasis on 0-3. Focus on: <ul style="list-style-type: none"> 1. decreasing rate and severity of maternal depression 2. identification, assessment and intervention services for young children at-risk of impaired attachment. <ul style="list-style-type: none"> a. include focus on reattachment issues b. encourage and foster the father/child bond c. identification of pregnant mothers at risk of poor attachment

EXPECTED RESULTS –

1. Children enter kindergarten socially and emotionally prepared to learn

SAMPLE INDICATORS –

1. Increase in the percentage of one-year olds who demonstrate secure attachments to their parents based on written objective criteria by a nurse, home visitor or mental health professional
2. Increased percentage of time during observations that mothers demonstrate attachment behaviors with their infants
3. Increase in the number of children who receive mental health screenings and appropriate referrals
4. Increase in the percentage of 1-year olds with positive screening indicators of attachment disorder who are assessed using a standard assessment protocol
5. Increase in the number of children who appropriately receive mental health services
6. Increase in the number of early childhood service providers who are trained to screen and appropriately refer children for mental health/psycho-social assessment
7. Increase in the percentage of 6-month old infants who are screened for indicators of insecure attachment

<u>OBJECTIVE</u>	<u>STRATEGIC DIRECTIONS</u>	<u>SCFFC APPROACH</u>
G. <i>IMPROVE LANGUAGE ACQUISITION AND FAMILY LITERACY</i>	<ol style="list-style-type: none"> 1. SYSTEMS <ol style="list-style-type: none"> a. make literacy, language development classes applicable toward Welfare-to-Work credit b. offer more neighborhood-based facilities and services c. develop a collaborative effort to increase and coordinate literacy and language services and resources 2. CAPACITY-BUILDING <ol style="list-style-type: none"> a. increase the number of interpreters available throughout the county b. increase the number of family literacy and language development providers c. expand library service access and learning activities, including those appropriate for children with special needs (i.e. book mobiles, storytelling) d. make more resources (books, magazines, audio tapes, videos) for literacy and language development available in the home (e.g. book giveaways, book swaps) 3. PARENT SUPPORT AND EDUCATION <ol style="list-style-type: none"> a. develop school outreach to parents that support family literacy (including pre-literacy skills) through home visits and ESL tutoring b. utilize hospitals and MDs to provide information on family literacy, literacy programs c. provide ESL tutoring and interpreter support in the community 4. PROVIDER EDUCATION AND TRAINING <ol style="list-style-type: none"> a. promote print/language-rich environments in early care and education settings 5. PUBLIC EDUCATION <ol style="list-style-type: none"> a. increase awareness about the value of reading to children, including the use of music as a technique for language acquisition 	<ol style="list-style-type: none"> 1. Support the development and coordination of project(s) to increase in-home and in-community reading/language use with young children 2. Support project focused on adult language development (ESL and Adult Basic Education) 3. Support the coordination of multi-lingual services and availability of multi-lingual materials

	6. SERVICES <ol style="list-style-type: none"> offer linguistically appropriate child care in conjunction with parent literacy and language programs offer books and reading (audio-tapes) to young children in MD/other waiting rooms, courthouse, public offices, family law offices, jail, etc. provide cultural and multi-lingual materials for children and families ensure access to services through transportation or other means 	
EXPECTED RESULTS – <ol style="list-style-type: none"> Children age 0-to-5 years old excel in language development Multi-lingual services are integrated into all systems and are accessible to non-English speaking families SAMPLE INDICATORS – <ol style="list-style-type: none"> Increase in the percentage of children who demonstrate reading readiness upon entering the first grade Increase in the number of providers delivering bilingual services and materials Increase in the number of ESL services available Increased percentage of 0-to-5 year olds who are read to daily by a parent or primary caregiver Increased percentage of 0-to-5 year old children who visit libraries and other learning resources Increased number of early care and education services that offer linguistically diverse programs Increased adult literacy rates 		

<u>OBJECTIVE</u>	<u>STRATEGIC DIRECTIONS</u>	<u>SCFFC APPROACH</u>
H. INCREASE THE NUMBER AND USE OF PARKS AND RECREATIONAL ACTIVITIES	<ol style="list-style-type: none"> CAPACITY-BUILDING <ol style="list-style-type: none"> develop play areas and increase recreational equipment for 0-5 year olds make neighborhood meeting spaces available develop flexibility of recreational programs to include children 0-5, including children with special needs PUBLIC EDUCATION <ol style="list-style-type: none"> educate families to become aware of the value of recreation inform public of recreational activities available publicize benefits of exercise publicize benefits of interactive, family-oriented play SERVICES <ol style="list-style-type: none"> encourage informal neighborhood recreational opportunities increase number of community activities offered in neighborhoods develop ways of increasing affordability of recreational opportunities for children support park departments' sponsorship of family fun days increase number of local parent/child playgroups 	<ol style="list-style-type: none"> Support efforts to increase park equipment and free/affordable recreational activities appropriate for 0-5 year olds Support development and coordination of free/affordable parent/child playgroups for 0-5 year olds Encourage local sponsorship and/or reduced fees for recreational activities appropriate for 0-5 year olds. Support community-based groups in developing neighborhood parks Support coordinated advocacy efforts to address planning issues involving the development of and access to parks and recreational activities for children 0-5. Support efforts to educate families with young children about available recreational facilities and activities

EXPECTED RESULTS –

1. Children age 0-to-5 years old and their families use parks often and are frequently involved in other recreational activities

SAMPLE INDICATORS –

1. Increased number of parks and public spaces available for family activities
2. Increased number of parks, gymnasiums and other health enhancing recreational spaces and programs available for family physical activities
3. Increased percentage of 0-to-3 year olds participating in playgroups
4. Increased number of booster swings and other equipment suitable for toddlers available in parks and recreational facilities
5. Increased number of free or reduced-price entrance fees to cultural arts programs
6. Increased number of available slots in recreational programs for 0-to-5 year olds
7. Increased number of community-wide events with activities planned for 0-to-5 year olds
8. Increased number of exhibits geared to young children, including exhibits that address cultural diversity
9. Increased percentage of 4 year olds who participate in neighborhood/community sports and recreational programs

<u>OBJECTIVE</u>	<u>STRATEGIC DIRECTIONS</u>	<u>SCFFC APPROACH</u>
I. IMPROVE EDUCATION AND SUPPORT FOR EARLY CARE AND EDUCATION PROVIDERS (INCLUDING LICENSE-EXEMPT PROVIDERS)	<ol style="list-style-type: none"> 1. SYSTEMS <ol style="list-style-type: none"> a. develop organized community-level infrastructure for the training and education of early care and education providers b. develop stronger linkages among community-based organizations involved in early care and education c. develop and manage a provider substitute list 2. CAPACITY-BUILDING <ol style="list-style-type: none"> a. increase the availability of professional level trainers within the community b. return Community Care Licensing to Shasta County c. promote the local availability of upper division ECE classes (i.e Simpson College and National University) d. develop meaningful incentives for providers to participate in training and education opportunities (e.g. higher reimbursement rates for providers who complete training/accreditation programs; recognition of credentials in a referral system) 3. PROVIDER EDUCATION AND TRAINING <ol style="list-style-type: none"> a. offer training/support for license-exempt providers caring for relatives b. offer education in business development skills for providers c. offer training in inclusion and special needs for all early care providers d. offer training regarding quality infant-toddler care e. offer parenting skills education that parents and family child care providers take together f. offer technical assistance for family child care providers via home visits 4. PROVIDER SUPPORT <ol style="list-style-type: none"> a. offer support groups for license-exempt providers b. offer home visits for license-exempt providers for support and technical assistance 	Sponsor a Training and Education Initiative for early care and education providers, ensuring access to training and education for providers in outlying areas

EXPECTED RESULTS –

1. Early care and education providers are well trained, educated and supported

SAMPLE INDICATORS –

1. Increase in the number of college ECE or child development units received in a year per caregiver
2. Increase in the percentage of unlicensed providers becoming licensed
3. Increase in the number and diversity of ECE college courses available in Shasta County
4. Establishment of a tracking system to monitor education and training levels of early care and education providers
5. Increase in the number of caregivers who have had their jobs for more than 12 months
6. Increase in the percentage of early care and education providers accessing qualified mentoring and networking opportunities
7. Increase in the number of exempt providers attending training and receiving incentives

<u>OBJECTIVE</u>	<u>STRATEGIC DIRECTIONS</u>	<u>SCFFC APPROACH</u>
J. <i>IMPROVE SCREENING, REFERRAL AND FOLLOW-UP ON REFERRALS FOR DEVELOPMENTAL DELAYS</i>	<ol style="list-style-type: none"> 1. SYSTEMS <ol style="list-style-type: none"> a. integrate health screening services (with particular attention to services for mobile populations) and improve linkages among provider facilities 2. CAPACITY-BUILDING <ol style="list-style-type: none"> a. develop a screening tool for developmental delays to be used as a standard by CHDP providers b. create more community-based health centers 3. COMMUNITY/PARENTAL SUPPORT AND EDUCATION <ol style="list-style-type: none"> a. provide family and community education about the stages of healthy child development b. offer prenatal information to all expectant parents about the possibilities of special needs c. promote family medical homes 4. PROVIDER EDUCATION AND TRAINING <ol style="list-style-type: none"> a. develop a CHDP providers recertification process to maintain consistent standards 5. SERVICES <ol style="list-style-type: none"> a. include screening for developmental delays at well-baby check-ups b. develop a traveling medical unit to do outreach, targeting mobile populations 	<ol style="list-style-type: none"> 1. Support a project to train and encourage CHDP providers and other health care providers to utilize a valid, reliable screening instrument for all children 0-5 years old. Project would include referral procedures, ongoing technical assistance and a CHDP provider recertification process 2. Support the development and dissemination of information to parents, CHDP providers and other health care providers regarding stages of healthy child development.

EXPECTED RESULTS –

1. Children age 0-to-5 years old receive adequate screening and referral for developmental delays and other special needs

SAMPLE INDICATORS –

1. Increase in the number of well-child exams per child before the age of 2 years old
2. Increase in the number of service providers who are trained to screen and appropriately refer for developmental assessments
3. Increase in the proportion of primary care providers who routinely refer or screen infants and young children for impairments of vision, hearing, speech and language, and who assess other developmental milestones as part of well child care
4. Increase in the percentage of children who demonstrate physical, cognitive, adaptive, language and/or social delay who are referred for further assessment
5. Increase in the percentage of children receiving early intervention services

<u>OBJECTIVE</u>	<u>STRATEGIC DIRECTIONS</u>	<u>SCFFC APPROACH</u>
K. DECREASE THE INCIDENCE OF DENTAL CARIES IN YOUNG CHILDREN	<ol style="list-style-type: none"> 1. CAPACITY-BUILDING <ol style="list-style-type: none"> a. increase the number of pediatric dentists b. increase the number of allied dental professionals familiar with pediatric dental care c. improve options for dental coverage 2. PARENT EDUCATION <ol style="list-style-type: none"> a. provide parent education classes and other learning opportunities regarding the maintenance of oral health during early childhood b. provide parent education about the benefits of fluoridation for young children 3. PROVIDER EDUCATION <ol style="list-style-type: none"> a. offer educational opportunities for dental care, health care and other providers regarding routine dental screening of young children b. inform dental and other providers about the local incidence of oral decay in young children c. provide information to dental care providers regarding the preventative benefits of fluoridation 4. PUBLIC EDUCATION <ol style="list-style-type: none"> a. conduct community awareness campaign regarding the importance of oral health during early childhood and the preventative benefits of fluoridation 	<ol style="list-style-type: none"> 1. Support the development and efforts of a Dental Coalition with broad representation from dental care providers, health care providers, early care and education providers, parents/community members and others.
<p>EXPECTED RESULTS</p> <ol style="list-style-type: none"> 1. Children entering kindergarten experience good oral health <p>SAMPLE INDICATORS</p> <ol style="list-style-type: none"> 1. Decrease in dental caries and disease for children entering kindergarten 2. Increase in the percentage of children receiving early dental services 3. Increase in the number of medical and dental care providers educated about the importance of addressing the oral health of children age 0-to-5 years old 		

EVALUATION PLAN

The Shasta Children and Families First Commission considers evaluation to be a critical part of our strategic plan. We want to know how we are doing. It is important to know whether we are making a difference in the lives of young children and their families. We also want to know whether we are directing our resources wisely and effectively. Evaluation allows us to keep track of our progress and it will allow us to identify the most effective approaches for achieving our expected results. It also will allow us to identify areas in which unmet needs continue to exist. Based on what we learn from evaluation, we will be able to continuously improve what we are doing in our efforts to enhance the well-being of our community.

We plan to approach evaluation from two different perspectives. First, from a *micro*-perspective, we will look at the specific programs and activities we support. Second, from a *macro*-perspective, we will look at the impact of our efforts on the overall population of young children and families in Shasta County.

To engage in evaluation of our programs and activities, an evaluation plan will be included as a significant element in each of our contracts and agreements. Potential contractors, grantees and partners will link their service plans to the sample *indicators* and expected *results* we have identified for measuring progress in accomplishing our objectives. Plans will be identified for collecting qualitative and quantitative data on service delivery and the results for families served. Evaluation will be included in every *scope of work* and periodic progress reports will be submitted. Furthermore, grantees/contractors/partners will be required to participate in the wider county and statewide evaluation efforts.

The population-based evaluation, the evaluation from a *macro*-perspective, is a long-term process to demonstrate the broad results of our work. Achieving results in the overall health and well-being of families takes time. Baseline data needs to be established as a point of comparison at a future point. We intend to begin immediately. An immediate priority is to contract with an evaluation consultant or organization who will develop a comprehensive data system. Evaluation instruments need to be developed as do protocols and timelines for data collection, reporting and dissemination. These efforts toward evaluation will be conducted in conjunction with state evaluation resources which are currently under development.

Our contract for evaluation also will provide for technical assistance to SCFFC-supported programs. We want to increase the capacity for evaluation throughout our programs so help will be offered in developing appropriate evaluation methodology, evaluation instruments, baseline data, measurement and data management.

The Shasta Children and Families First Commission will work in collaboration with the State Commission and with other local commissions in evaluating the effects of Proposition 10 on children across California. We want to be sure that our families are stronger, that our children are learning and ready for school, and that our children are healthy.

We want to be sure we can answer *all the children are well* when we ask each other
How Are the Children?

RESOURCE ALLOCATION PLAN

Early in its strategic planning process the Shasta Children and Families First Commission identified principles to guide its overall operation and approach to allocating resources.

OPERATING PRINCIPLES

The SCFFC is committed to practices that are:

Ethical, honest and integrity-based
Open and accountable to the community
Fiscally responsible
Research/outcome based

SCFFC funding will emphasize:

Consistency with SCFFC statements of vision and mission
Prevention and early intervention
Focus on the first three years of a child's life
Early brain development in children
Building on the strengths and assets of our community
Integrated systems of practice
Maximization of community resources and revenues
Cost-effective programs
Diversity and cultural competence

SCFFC APPROACH TO RESOURCE ALLOCATIONS

1. The Shasta Children and Families First Commission (SCFFC) places a priority on addressing the needs and interests of the community. To this end it intends to channel as much of its available resources into the community as is prudent. In total, 80% of revenues will be allocated for programs, services and activities. This includes 5% which will be held for unexpected program opportunities and/or opportunities for the leveraging/matching of funds in programs related to the aims of the SCFFC vision, mission and objectives. It also includes 5% which will be allocated for programmatic technical support services.
2. Approximately 10% of a year's revenue will be applied to administrative operation.
3. An additional 10% will be applied to evaluation systems and data collection

4. SCFFC will aim to maintain a balanced stream of funding which recognizes program revenue and expenditures and to stagger funding allocations throughout the year. Funding allocations will not be made merely to satisfy an allocation formula.
5. Priority will be given to proposals which provide opportunities for fund leveraging, although seeking opportunities to leverage funds will not drive our funding allocation process.
6. We will seek and promote *multi-agency* collaboratives – collaborative efforts that are inclusive of the private sector, community groups, non-profits, the faith community and others.
7. SCFFC favors funding efforts that lead to systemic change. We seek to increase the capacity of members and organizations of our community to address the health and well-being of prenatal to five year old children. This building of capacity may be accomplished through the development and provision of direct services; through efforts that affect attitudinal change; and through efforts to expand abilities. We will seek to build upon the *natural resources* of our neighborhoods and communities as well as the resources of our professional community.
8. The Commission also is interested in making awards of seed money to provide opportunities for innovative projects.
9. A variety of allocation vehicles will be utilized including mini-grants, short-term project awards, planning grants followed by implementation support, and contracts for services. It may be possible that the SCFFC becomes a direct provider of service.
10. Most allocations of funds will be made as individual awards, although block grants may be considered, being awarded only with clearly agreed-upon outcome measures and safeguards. The Commission will consider the private sector's ability to provide service before turning to the public sector, with the assurance that funds will not be used to supplant existing, publicly- or privately-funded programs. Government programs will be funded only for efforts in which monetary or non-monetary matching resources are available.
11. Flexibility will exist in the types of allocation arrangements we create, to include grants, contracts, and Memoranda of Understanding/agreements. The SCFFC recognizes that each of these arrangements varies by degree of flexibility, independence and influence and will articulate its reasoning for utilizing each of them. Furthermore, broad variations in the length of awards will be incorporated; these could range from one year to three-or-four years in length. It is important to note that an award of funding is not to be perceived by recipients as support which will be sustained. To avoid mistaken proprietary attitudes from recipients, clear limits will be set and expected results agreed

upon. In all instances, continuation of funding, even within a given award period, will be contingent upon satisfactory accomplishment of performance criteria.

12. The Commission will take into consideration the administrative efficiency and monitoring efforts required when determining the number and amount of allocations awarded. The Commission recognizes that larger allocations represent the larger chance of impact yet also require higher administrative costs and managerial experience. At the other end of the funding spectrum, SCFFC will not stipulate a minimum allocation amount.
13. All of our funding relationships will be performance-based and will require agreed-upon procedures for monitoring and evaluating. We will attend closely to contract language to clearly define deliverables, thus ensuring that our desired outcomes are addressed.
14. While some geographic criteria will be considered (i.e. distance and specific populations), funding will be awarded according to demonstrated need. Funding will not be awarded along lines of political jurisdictions.
15. Proposals submitted for funding will be reviewed by a community advisory committee of readers, which is appointed by the Commission. The advisory committee will read and rank the proposals according to Commission guidelines in a public environment and make recommendations to the Commission. If a Commissioner's agency is one of the proposals being recommended for funding, that Commissioner will abstain from discussion and voting on that specific proposal.

"HOW ARE THE CHILDREN?"

APPENDIX A

Summary of Information Provided to SCFFC May – December 1999

A tool for use in Strategic Planning
February 2000

Based on research conducted by
Donnell Ewert

Summary compiled by
Doreen Bradshaw
In consultation with Muffy Berryhill

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Strategic Framework

Planning for an Easily Accessible, Consumer Oriented and Integrated System of Services

**“Ensuring Every Child is a Wanted Child”
Family Planning**

**“Ensuring the Birth of Healthy Babies”
Prenatal Care**

**“Building Parenting Supports”
Birth to 12 Months
Parent-Infant Attachment & Parenting Education
Bonding and Breastfeeding**

**“Enhancing Childhood Development”
1 to 3 Years
Child Care
Early Intervention**

**“Improving School Readiness”
3 to 5 Years**

Family Planning

“Ensuring Every Child is a Wanted Child”

DEFINITION

Intended pregnancy: a pregnancy which is wanted at the time of conception or sooner, regardless of contraceptive use

Unintended pregnancy: a pregnancy which is unintended at conception, regardless of contraceptive use

IMPACT TO SHASTA COUNTY

- Approximately 1,500 abortions obtained by Shasta County residents each year
- In 1997, there were 515 births to unmarried women aged 20 years and older (31% of births to women in that age group)
- In 1997, there were 336 additional births to teen mothers
- 66% of births to teen girls are fathered by men over 19

CONSEQUENCES OF UNINTENDED PREGNANCY

Women with unintended pregnancies are:

- Less likely to fully participate in prenatal care
- More likely to smoke and drink during pregnancy
- More likely to deliver low birth weight babies
- More likely to have babies that die in the first year of life
- More likely to have babies that suffer poor child health and development, including physical abuse and neglect
- Unable to prepare for pregnancy
- Unable to benefit from preconceptual genetic risk assessment and disease management

For the child, increased risk of:

- Low birth weight
- Preterm birth
- Infant mortality
- SIDS
- Physical abuse and neglect
- Poverty
- Lack of father in home
- Poor educational performance
- Unprepared parents
- Exposure to substance abuse in utero
- Birth defects

CONSEQUENCES OF UNINTENDED PREGNANCY – CONTINUED

For the woman increased risk of:

- Depression
- Physical Abuse
- Low educational attainment
- Limited job opportunity
- Poverty
- Single parenthood
- Maternal mortality
- Inadequate prenatal care
- High risk pregnancy

For society increased risk of:

- Expense of public and private medical insurance for deliveries, abortions, infants and children
- Welfare benefits
- High abortion rate
- Greater juvenile delinquency
- Lifelong cost of caring for persons with birth defects
- Child care needs

STRATEGIES

- Educate public about major social, health and economic burdens of unintended pregnancy for mother, baby and society
- Improve knowledge, attitudes and skills related delaying sexual activity, contraception and reproductive health
- Increase access to preconceptual counseling and contraceptive methods
- Develop or enhance locally accessible programs to reduce unintended pregnancy

INDICATORS

- Age at first intercourse
- Ever having unprotected sexual intercourse
- Number of times participating in unprotected sexual intercourse in the past month
- Whether or not a contraceptive method/device was properly used at last intercourse
- Ever experiencing/causing an unintended pregnancy
- Number of unintended pregnancies experienced/caused in the past year

Prenatal Care

“Ensuring the Birth of Healthy Babies”

DEFINITION

Screening of pregnant women to prevent or detect abnormal development of child and support for the woman’s mental and social well-being during pregnancy; provision of health information and skill building regarding smoking, substance abuse, nutrition and exercise during pregnancy

IMPACT TO SHASTA COUNTY

- 66.1% of women in Shasta County had adequate or adequate-plus prenatal care, compared to 67.1% of women in California
- Compared to California, Shasta County has slightly better race specific rates for obtaining prenatal care for every race except Asians
- Of the 14 infant deaths in Shasta County in 1998-99 for which prenatal care information was available, only 9 of them had mothers who began prenatal care during the first trimester

HEALTHY PEOPLE 2000 OBJECTIVE

Increase to at least 90% the proportion of all pregnant women who receive prenatal care in the first trimester of pregnancy

CONSEQUENCES OF INADEQUATE PRENATAL CARE

- Low birth weight
- Pre-term birth
- Infant mortality
- Congenital/birth related infections
- Inappropriate growth in the first year of life
- Genetic disorders

BARRIERS TO PRENATAL CARE

System-related

- Inadequate public and/or private insurance
- Transportation problems
- Lack of child care
- Language and cultural incompatibility between providers and clients
- Limited information on where to obtain care

BARRIERS TO PRENATAL CARE - CONTINUED

Socioeconomic

- Poverty
- Rural or inner-city residence
- Minority status
- Unmarried
- Less than high school education

Attitudinal

- Pregnancy unplanned
- Signs of pregnancy unknown
- Prenatal care not valued
- Fear of doctors/hospitals
- Fear of deportation or problems with INS
- Fear that certain health habits will be discovered

BENEFITS OF PRENATAL CARE

- Improve birth outcomes
- Prevent illness related to pregnancy
- Prevent fetal death before birth

COST SAVINGS

- Net savings of \$1.50 for every \$1.00 spent on prenatal care
- Hospital cost savings for women who receive prenatal care is over \$1,000 per birth

STRATEGIES

- Ensure early entry into and increase access to comprehensive prenatal services for all pregnant women
- Increase linkages between services to promote long-term physical and psychosocial well-being
- Support and promote breastfeeding before birth
- Meet the specific needs of high-risk mothers
- Advocate for culturally appropriate prenatal care services

INDICATORS

- % of women attending their first prenatal care visit within the first trimester of pregnancy
- % of pregnant women receiving appropriate prenatal care
- % of all infants born before 37 weeks gestational age
- % of all infants born with birth weights below 2500 grams
- % of all infants exposed to tobacco, alcohol and/or other drugs during pregnancy
- % of women who intend to breastfeed

Building Parenting Supports Birth to 12 Months

“Breastfeeding and Bonding”

DEFINITION

BREASTFEEDING

Exclusive: mother only feeds infant breast milk during the first 5-6 months of age

Partial: mother breastfeeds infant but offers supplemental feedings with formula

Artificial: mother offers infant only supplemental sources of nutrition, including cow's milk and formula

MATERNAL-INFANT BONDING

Breastfeeding increases the bond between the mother-infant dyad, and bonding increases the enjoyment and success of breastfeeding. The mother-infant bond is the strongest human bond and is intertwined with breastfeeding.

IMPACT TO SHASTA COUNTY

- In Shasta county WIC during fiscal year 1994-95, 24% of 1114 enrolled infants were breastfed (for unknown duration)
- During May 1999, 35% of enrolled infants were breastfed in Shasta County WIC

HEALTHY PEOPLE 2000 OBJECTIVE

- Increase to at least 75% the proportion of mothers who breastfeed their babies to the early postpartum period
- Increase to at least 50% the proportion of mothers who breastfeed their babies until they are 6 months old
- Increase to at least 25% the proportion of mothers who breastfeed their infants until they are one year old

CONSEQUENCES OF DEPRIVATION OF INFANT CONTACT

Infant

- Deficits in mental and motor development
- General failure to thrive

Mother

- Loses interest in child
- May abandon baby

BARRIERS TO BREASTFEEDING

- Health professionals agree that breast is best, but do not counsel patients
- Advice about breastfeeding is inconsistent
- Hospital policies that include separation of mother and baby, scheduled feedings, supplementation with bottled formula or water and formula give-aways
- Employer policies affecting working mothers
- Public attitudes towards women who breastfeed in public

BENEFITS OF BREASTFEEDING

For Infant

- Human milk is nutritionally complete
- Human milk contains factors that help infants grow and develop
- Human milk protects infants from infectious diseases
- Breastfed infants are less likely to suffer from lower respiratory illness and ear infections
- Breastfeeding is protective against bacterial infections
- Breastfeeding reduces the risk of “baby bottle tooth decay”
- Breastfeeding is protective against infant botulism
- Breastfed infants are less susceptible to some chronic diseases
- Exclusive breastfeeding is protective against SIDS
- Human milk is especially important for premature infants

For Mother

- Breastfeeding promotes rapid recovery after childbirth
- Breastfeeding mothers return to their prepregnancy weight more rapidly than bottle-feeding mothers
- Breastfeeding can be an important factor in child spacing
- Breastfeeding reduces the risk of breast and ovarian cancers
- Breastfeeding may protect women from other chronic diseases
- Women who breastfeed are more relaxed and have less anxiety, stress and depression

For Society

- Improves overall intellectual abilities of population
- Decreases unintended pregnancies
- Reduces child protective services/foster care budgets
- Reduces medical/dental treatment expenses
- Reduces cost of infant feeding
- Reduces pollutants that would be produced during manufacture of formula
- Reduces burden on landfills

BENEFITS OF BREASTFEEDING - CONTINUED

For Early Maternal-Infant Contact

- Increases degree of bonding
- Increases nurturing behaviors like increased holding time, soothing and relaxed touch
- Decreases the likelihood of mental illness later in life
- May raise IQ

STRATEGIES

- Promote breastfeeding policies at hospitals and work-sites
- Inform all pregnant women about the benefits and management of breastfeeding
- Help mothers initiate breastfeeding within 30 minutes of birth
- Show mothers how to breastfeed and how to maintain lactation even if they should be separated from their infants
- Give newborn infants no food or drink other than breast milk, unless medically indicated
- Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic
- Provide private space at work to support breastfeeding
- Allow breaks, flexible work hours, part-time work and job sharing so that women can pump milk or breastfeed their infants

INDICATORS

Breastfeeding

- % of women who decide during the prenatal period to breastfeed their infants
- % of women who initiate breastfeeding in the early postpartum period
- Average number of months mothers who breastfeed their infants
- % of women who breastfeed their infants until six months of age
- % of women who breastfeed their infants until one year of age
- % of pregnant women whose most significant social support person is supportive of breastfeeding

Maternal-Infant Bonding

- Average number of minutes that mother and child spend in physical contact during the first hour of life
- % of women who have breast-infant contact during the first hour of life
- % of women who elect to room-in with their infants during their postpartum hospital stay
- Average % of time during an observation period that mothers demonstrate the enface posture
- Average % of time during an observation period that mothers demonstrate attachment behaviors with their infants

Building Parenting Supports Birth to 12 Months

“Parent-Infant Attachment & Parenting Education”

DEFINITION

Parent-Infant Attachment

Lasting psychological connectedness between human beings

Parent Education

Resources, activities, services and programs offered to parents that are designed to increase their capacity and confidence in raising healthy children

CONSEQUENCES OF INSECURE ATTACHMENT

- Increased use of acute care facilities (walk-in emergency)
- Increase in maternal and childhood depression
- Increase in the child’s inability to manage and control emotions

BENEFITS OF SECURE ATTACHMENT

<i>Infant</i>	Optimal brain development, higher self-esteem, more independence and autonomy, more resilience in the face of adversity, greater social skills, quality long-term friendships
<i>Parent</i>	Less crying and fussiness with baby, more positive interactions and feedback with the child, close emotional connection with the child and more harmonious family relationships
<i>Society</i>	Lower medical costs, lower foster care costs, less aggressive and violent citizens, lower law enforcement and incarceration costs and more abiding, ethical and compassionate citizens

STRATEGIES

- Provide early intervention by midwives, health visitors and other primary health professionals
- Utilize parent participation in development and operation of community-based parenting programs
- Expand existing services to include or enhance a focus on parent education
- Provide high quality child care to all children that need it
- Expand home based programs to educate new parents on child development and family life skills
- Extend evening parenting programs and/or therapy for mothers with depression

STRATEGIES CONTINUED

- Create an integrated program that involves multiple channels of communication and delivers unified messages to parents
- Develop telephone support or “warm lines”
- Extend resources for peer support, group support, group therapy and individual

INDICATORS

PARENT-CHILD ATTACHMENT

- Average score of pregnant women on the Maternal-Fetal Attachment scale
- % of infants who demonstrate secure attachment to their parents according to the strange situation classification
- Average score of children aged 12 months on the Attachment Q-Set
- % of infants who demonstrate secure attachment to their parents based on written objective criteria used by a visiting nurse or home visitor
- % of infants who demonstrate secure attachment to their parents based on written objective criteria used by a psychologist, counselor, or social worker

PARENTING AND EDUCATION

- % of persons that parents of infants can call upon for help with a crisis or emergency
- % of 12 month old infants who are read to daily by a parent
- Average score of parents of infants on the Parenting Sense of Competence
- Average score of parents of infants on the Knowledge of Infant Development Inventory
- % of 12 month old infants who have at least one parent who demonstrates more than one disciplinary method/strategy
- % of infants who have at least one parent who has used illicit drugs and/or has five or more alcoholic drinks in one day during the past month
- Average score of parents of infants on the Child Abuse Potential inventory

Enhancing Childhood Development 1 to 3 Years

“Early Intervention”

DEFINITION

- Ability to see, hear, or move
- Ability to think and learn
- Ability to understand, talk, express self
- Ability to relate to others
- Ability to eat, dress, and care for or help self

IMPACT TO SHASTA COUNTY

- Shasta County Office of Education spends \$8.5 million annually on special education
- A total of 3,529 students with specific disabilities are enrolled in Shasta county Schools

CONSEQUENCES OF LACK OF EARLY INTERVENTION

- Increased likelihood of school difficulty
- Increased likelihood of child abuse
- Expensive special education and services later in life

BENEFITS OF EARLY INTERVENTION

Child

- Improved developmental status maximizes potential
- Improves cognitive abilities and social adjustment
- Maximizes learning potential of the child during key time of brain development
- Reduces child abuse and neglect
- Decreases rate of repeating grade level at school
- Increases employability as an adult

BENEFITS OF EARLY INTERVENTION - CONTINUED

Parents

- Increases knowledge of child development and appropriate expectations
- Links families with children with similar delays
- Increases parenting confidence and satisfaction
- Increases ability to cope with added burden of a delayed child
- Fosters understanding and intimacy with child
- Relieves financial burden

Society

- Improves community's awareness of persons with disabilities and their gifts
- Decreases need for expensive special education and other services later in life
- Increases high school graduation rate

COST SAVINGS

- Every \$1 spend on early intervention saves \$4

STRATEGIES

Comprehensive screening to include the following components:

Sensitivity to parental concerns

Thoughtful inquiry about parental observations

Observation of a wide variety of child's behaviors

Examination of specific developmental attainments

Use of all encounters for observing and recording developmental status

Screening of vision and hearing to rule out sensory impairment as cause of delay

Observation of parent-child interaction

INDICATORS

Access to Primary Care

- Average number of well child exams per child before age 2 years
- % of CHDP-eligible children aged 0-5 who are enrolled in CHDP

Maternal-Infant Bonding

- % of all children aged 12 months who are screened for developmental delays at least six times during the first year of life
- % of all children aged 24 months who are screened for developmental delays at least two times during the second year of life

Referrals

- % of children who demonstrate a developmental delay in at least one of five major areas (physical, cognitive, adaptive, language, social) who are referred by primary providers for further assessment

Enhancing Childhood Development 1 to 3 Years

“Child Care”

DEFINITION

FAMILY CHILD CARE

Provider cares for unrelated children in her own home; may be licensed or non-exempt from licensing

CENTER-BASED CARE

Open five days a week to serve infants, toddlers, preschoolers and school-aged children

PRESCHOOLS

Includes private and government sponsored preschools; usually part day, part year program for three and four year olds

IMPACT TO SHASTA COUNTY

- 4,225 child care slots exist in the licensed sector, which is about two-thirds of the child care demand
- cost for child care ranges from \$300 to \$550 a month, depending on child’s age and quality of care
- Most pressing needs are more infant slots, more slots for children with special needs, lack of effective transportation and more child care slots during non traditional working hours

BENEFITS OF HIGH QUALITY, ACCESSIBLE CHILD CARE

- Children who attend child care with higher quality classroom practices had better language and math skills from the preschool years into elementary school
- Children with closer teacher-child relationships in child care had better classroom social and thinking skills, language ability, and math skills from the preschool years into elementary school
- Children who experienced more positive classroom climates in child care had better relationships with peers in second grade
- Better child care quality was more strongly related to better math skills and fewer problem behaviors from the preschool years through second grade for children whose mothers had less education

STRATEGIES

- Develop mechanisms to increase child care availability in non-traditional hours
- Develop mechanisms to increase child care spaces for infants and children with special needs
- Provide child care which is accessible by public transportation
- Develop/coordinate funding systems for child care
- Provide increased financial support to meet child care costs needed by the working poor
- Promote/provide higher education, continuing education for caregivers
- Educate parents with regards to important factors in making quality child care selections
- Promote the development and provision of quality child care

INDICATORS

CHILD CARE AVAILABILITY

- % of needed child care spaces that are in licensed centers or licensed family-care homes
- % of needed child care spaces for children and families with special needs that are available in licensed centers or licensed family care-homes
- # of subsidized child care spaces per 1,000 children aged 0-4 years living in households with incomes below the federal poverty level

CHILD CARE QUALITY

STRUCTURAL

- Average ratio of children-to-caregivers in child care setting
- Average number of children per care group
- Average number of college credits received in child development or early childhood education per caregiver
- Average number of years of formal education per caregiver
- Average number of years of experience working in child care or early childhood education per caregiver

Caregiver Satisfaction Indicators

- % of Caregivers who change jobs in a 12 month period
- % of Caregivers who leave the child care profession in a 12 month period

Process Indicators

- Average score on the Caregiver Interaction Scale
Average score on the early childhood Environmental Rating Scale

Improving School Readiness 3 to 5 Years

DEFINITION

A child that is ready for school is healthy, able to effectively communicate, enthusiastic about learning and has cooperative social skills

BENEFITS OF CHILD SCHOOL READINESS

Child

- Higher IQ scores and better school achievement
- Improved language skills
- More stimulating environment for learning
- Less likelihood of being labeled “retarded”
- Greater income potential later in life
- Less risk of incarceration later in life

Parents

- Quality child care availability, which facilitates employment
- Fewer behavioral problems with child

Society

- Less grade retention and special education services
- Greater high school graduation rate
- Better socialization
- Increased employment and less crime

COST SAVINGS

- The lifelong cost of not providing at least two years of quality early childhood education is \$108,000 for each child born into poverty (crime \$70,000; unemployment \$30,000; special education and grade retention \$7,000; and welfare/child care \$1000)

STRATEGIES

Parents

- Recognize parents as the primary teachers of their children
- Enhance abilities of parents to foster learning
 - displaying confidence in their child's ability
 - valuing education
 - encouraging and stimulating natural curiosity
 - providing a variety of new experiences
 - showing a constant interest in child's progress
 - talking with children
 - listening to children
 - reading to young children
 - setting challenging but reasonable goals
 - giving prohibitions and corrections without anger
 - encouraging their children to measure current achievements against previous efforts, not other children

Community

- Promoting reading through such volunteer programs as "Reach Out and Read"
- Expand provision of quality early childhood education programs
- Combine quality early childhood education with interventions to help parents

Health Issues

- Good nutrition
- Decreased exposure to environmental tobacco smoke
- Immunizations
- Screening for lead
- Prevention of childhood injury
- Regular dental exams and fluoridated water

INDICATORS

Early Childhood Education

- % of four year old children eligible for Head Start who are enrolled in Head Start
- % of children aged 3 and 4 years who are enrolled in early childhood education
- % of children aged 3 or 4 years who are read to daily by a family member

Kindergarten Behaviors

- % of kindergarten students who generally are not sleepy or tired in class
- % of kindergarten students whose speech is not hard to understand
- % of kindergarten students who generally are enthusiastic and interested in many different things
- % of kindergarten students who generally demonstrate appropriate behavior in turn-taking and sharing

INDICATORS - CONTINUED

Health and Wellness

- % of children enrolled in kindergarten who are exposed to second hand smoke in their homes
- % of children up-to-date on immunizations at time of enrollment in early childhood education programs
- Number of traumatic brain injuries each year among children aged 0–4 years per 100,000 children aged 0-4 years
- Number of reported cases of children aged less than 5 years with blood lead levels exceeding 10 ug/dL per 100,000 children aged 0-4 years
- Average number of dental caries, filling or missing permanent teeth per child enrolled in kindergarten

"HOW ARE THE CHILDREN?"

APPENDIX B

Shasta Children and Families First Commission

COMMUNITY ASSESSMENT

Information Summary

Related to

Prenatal-to-5 years Olds
and Their Families

Summary of Community Assessments

May 2000

Over the past four years, many assessments have been conducted to ascertain the behaviors, needs and patterns of service utilization of the Shasta County community. These assessments have been conducted by state and county governmental entities as well as by community-based organizations. As part of its strategic planning process, the Shasta Children and Families First Commission studied several of these assessments with an eye for data, observations and conclusions pertaining to prenatal to five year old children and their families. What follows is a comprehensive compilation of this information.

The information in this report is organized into specific categories:

<u>TOPIC</u>	<u>PAGE</u>	<u>TOPIC</u>	<u>PAGE</u>
Prenatal Care	65	Children with Special Needs	80
Perinatal & Infant Deaths	66	Child Safety	80
Low Weight Births	67	Maternal Education Level	81
Births to Teenage Mothers	68	Poverty	82
Breastfeeding	69	Transportation	83
WIC	69	Mental Health	84
Immunizations	70	Family Violence/Child Abuse	85
Access to Health Care	71	Substance Abuse	86
Health Insurance Coverage	72	Tobacco Use	87
Dental Care	74	Coordination of Services	88
Early Care & Education	75	Others' Conclusions/Goals	90
		References	93

Following each data item or comment in this report is the source from which it originated. These citations are abbreviated throughout the text, with full references listed at the end of the report. For the most part, the wording in this report reflects the wording of the original assessments.

In instances where similar data was found in more than one source, only the most recent assessment is cited.

PRENATAL CARE

Throughout the 1990s, a significantly higher proportion of pregnant women received prenatal care during the first trimester in Shasta County than in California as a whole. However, Shasta County has not seen a significant increase in the first trimester utilization of prenatal care during the 1990s while California has experienced a sharp increase in utilization. The percentages of women obtaining prenatal care in the first trimester during 1995-97 in Shasta county by race were 87% for whites, 80% for African-Americans, 78% for Asians, 78% for Hispanics, and 71% for Native Americans. Shasta County women aged less than 17 years were less likely to get prenatal care in the first trimester than women aged 17 years and older (78% vs. 85%). Shasta County has yet to reach the *Healthy People* goal to increase to 90% the proportion of all pregnant women who receive prenatal care in the first trimester of pregnancy. MCAH

	Shasta Co.	US	Healthy People 2000 Goal
% No Prenatal Care in 1 st Trimester	14.6	18.1	10

CHW/PRC

Shasta County

LATE/NO PRENATAL CARE	1995	1996	1997
All	3.8%	2.4%	2.5%
African-American	13.3%	17.4%	4.3%
Asian	4.3%	1.6%	1.8%
Latino	1.4%	6.1%	4.3%
Native American	9.1%	4.7%	6.8%
White	3.7%	1.8%	2.1%

CN

	Shasta Co. Ranking	# of Counties
Late/no prenatal care	8	49

CN

Adequacy of prenatal care

(definition: the percent of live born infants whose mothers did not receive adequate prenatal care as defined by the Kessner Index.) The Kessner Index takes into account three factors – month in which prenatal care began, number of prenatal visits, and length of gestation. MCAH

While it is not possible to determine a trend in Shasta County with only two years of data, California has seen a decline in inadequate prenatal care during the 1990s. MCAH

In Shasta County, 66.1 out of every 100 1995-97 births received prenatal care that was adequate or more than adequate. This is just below the statewide index (67.1), but well below the U.S. index (73.3). CHW/PRC

Every \$1 spent on prenatal care saves \$3. LWV

PERINATAL & INFANT DEATHS

Fetal death

The fetal death rate has declined significantly in California during the 1990's, but has not changed in Shasta County. On average, Shasta County and California have very similar fetal death rates. California has not achieved the *Healthy People 2000* objective of no more than 5 fetal deaths per 1,000 births, and Shasta County only achieved this goal during the 1991-93 three-year period. MCAH

Infant Mortality

Between 1993 and 1995, there was an annual average of 7.3 infant deaths per 1,000 live births, close to the *Healthy People 2000* goal of 7.0 or less. Once high, this rate appears to be declining and is very close to the statewide rate. Nationwide, the rate is also declining, but is slightly higher. CHW/PRC

Shasta County

INFANT MORTALITY RATES (per 1,000)	1995	1996	1997
All	6.9	5.9	8.5
African-American	0.0	0.0	0.0
Asian	0.0	0.0	0.0
Latino	6.8	6.8	7.1
Native American	0.0	0.0	0.0
White	7.5	6.4	9.5

CN

	Shasta Co. Ranking	# of Counties
Infant mortality	28	37

CN

Neonatal mortality

Neonatal mortality (the number of infant deaths per 1,000 live births occurring at less than 28 days of age) has declined significantly in California this decade. There has also been a decreasing trend in neonatal mortality in Shasta County, from 4.8 during 1991-93 to 3.8 during 1995-97. California has met the *Healthy People 2000* objective of no more than 4.5 neonatal deaths per 1,000 live births since 1992, and Shasta County has met the goal in every three-year period since 1993-95. MCAH

Risk Factors

Race/ethnicity (Black); maternal diabetes; pregnancy complications; maternal medical complications/chronic illness during pregnancy (including severe maternal infection); Rh sensitization; congenital anomalies; intrauterine cocaine exposure; maternal history of miscarriage. MCAH

Post-neonatal mortality

Post-neonatal mortality (the number of infant deaths per 1,000 live births occurring between 28 and 364 days of age) has declined in California this decade, but has remained relatively static in Shasta County. During both 1991-93 and 1995-97, the post-neonatal mortality rate was 3.3 per 1,000 live births in Shasta County. While California has met the *Healthy People 2000* objective of no more than 2.5 post-neonatal deaths per 1,000 live births since 1995, Shasta County has reached this goal only during the 1992-94 three-year period. Of all infant mortality it is in the post-neonatal portion that Shasta County has had higher rates than California during the 1990's. MCAH

Risk Factors:

Congenital anomalies; injuries; infection in late pregnancy; family history of SIDS; maternal smoking or drug use; young maternal age (teen births); race/ethnicity (Black, American Indian, Puerto Rican). MCAH

LOW WEIGHT BIRTHS

Low birthweight babies, those who weigh less than 2,500 grams at birth (roughly 5 pounds, 8 ounces), are much more prone to illness and infant death than are babies of normal birthweight. Largely a result of receiving poor or inadequate prenatal care, many low weight births and the consequent health problems are preventable.

Between 1995 and 1997, an annual average 5.1% of babies born in Shasta County were classified as being of low birth weight. This is slightly lower than the percentage of low birthweight babies recorded statewide (6.1%), as well as the percentage recorded nationwide (7.4%)

The *Healthy People 2000* goal is to reduce to 5% or less the number of women delivering low-weight babies. CHW/PRC

Shasta County

PERCENT LOW BIRTHWEIGHT INFANTS	1995	1996	1997
All	5.6%	5.0%	4.8%
African-American	13.3%	4.3%	8.7%
Asian	10.0%	6.5%	8.9%
Latino	6.2%	5.4%	5.0%
Native American	1.3%	9.3%	4.5%
White	5.5%	4.7%	4.6%

CN

	Shasta Co. Ranking	# of Counties
Low birthweight infants	11	49

CN

BIRTHS TO TEENAGE MOTHERS

Teenage mothers are often at higher risk of problems associated with improper or inadequate prenatal care, especially in minority and lower socio-economic populations. They have a higher than average chance of suffering pregnancy complications, are less likely to ever complete a high school education, and earn about half the lifetime income of women who first give birth in their 20's. CHW/PRC

In Shasta County, 6.5% of 1997 births were to mothers under the age of 18 years; this proportion is above the 4.6% record statewide. In addition, 16.8% of 1997 births in Shasta County were to mothers under the age of 20, compared to only 11.7% statewide. CHW/PRC

Adolescent Birth Rate

The birth rate among adolescents in Shasta County in 1995-97 was 54.2 births per 1,000 girls aged 15 to 19. This translates to approximately 1 out of 20 teenage girls giving birth. Statewide, the adolescent birth rate is higher at 61.7 per 1,000 teenage girls. CHW/PRC

Shasta County

TEEN BIRTH RATES (PER 1,000)	1995	1996	1997
All	52.7	55.0	55.0
African-American	115.4	108.7	235.3
Asian	62.5	63.5	19.7
Latino	87.6	97.2	106.1
Native American	111.1	58.5	108.3
White	47.2	51.1	49.5

CN

	Shasta Co. Ranking	# of Counties
Teen births	25	52

CN

In Shasta County in 1995, a slightly higher proportion of low birthweight infants was born to teenage women than to women aged 20 years or older – 7% were to women under 18, while 6.5% were to women over 20 years. LWV

Repeat births to teens in the county have shown a decreasing trend, dropping from 26.5% of teen births in 1991 to 17.5% in 1995 for women under age 20, and declining from 11.8% in 1991 to 3.4% in 1995 for women under age 18. LWV

BREASTFEEDING

Shasta County

MOTHERS WHO INITIATE EXCLUSIVE BREASTFEEDING	(1997)
Percent	79%

CN

	Shasta Co. Ranking	# of Counties
Mothers who initiate exclusive breastfeeding	5	58

CN

HEALTHY PEOPLE 2000 OBJECTIVE:

Increase to at least 75% the proportion of mother who breastfeed their babies in the early post-partum period. MCAH

YEAR 2000 NATIONAL OBJECTIVE

To increase to at least 50% the proportion who continue breastfeeding until their babies are 5 to 6 months old. HIP

2000-01 Goal of Shasta County Maternal Child Adolescent Health: to increase to at least 13% the proportion who continue to breastfeed until their infants are 6 months old. MCAH

WIC

Every \$1 spent on WIC is estimated to save \$3 in medical costs. The greatest cost-savings associated with the WIC program occur during the first year of life due to reduced medical costs. WIC is attempting to establish pick-up sites for vouchers, where clients may also obtain other services. WIC is now on-line with computers, enabling staff to track clients and provide faster delivery of services if clients move. LWV

Shasta County

CHILDREN RECEIVING WIC ASSISTANCE	(1997 – Ages 0-4)
Number of participants	3,625
Percent of all eligible	57.3%

CN

	Shasta Co. Ranking	# of Counties
Children receiving WIC assistance	43	58

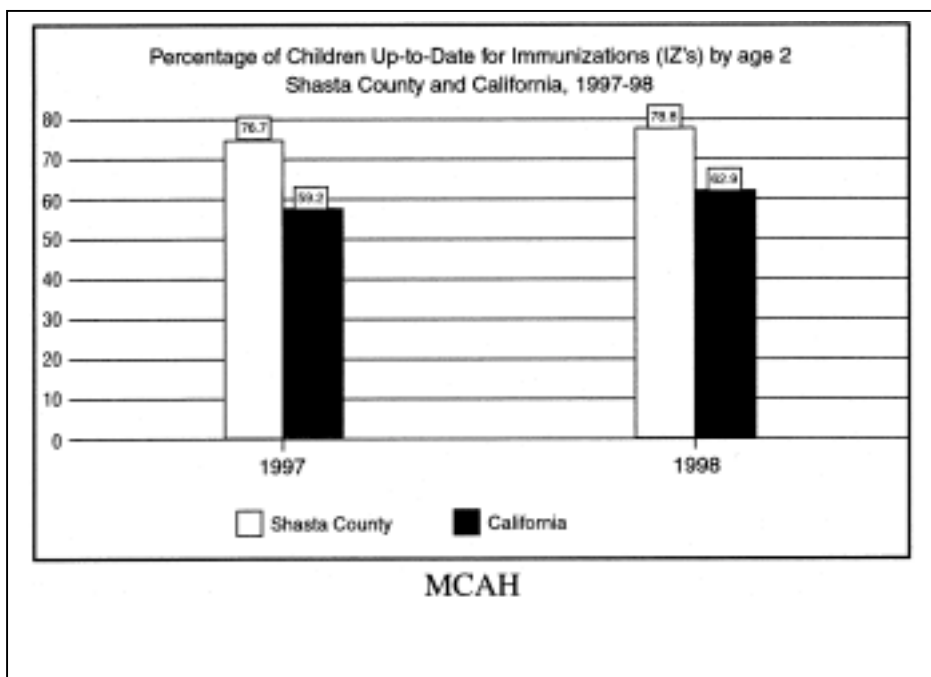
CN

IMMUNIZATIONS

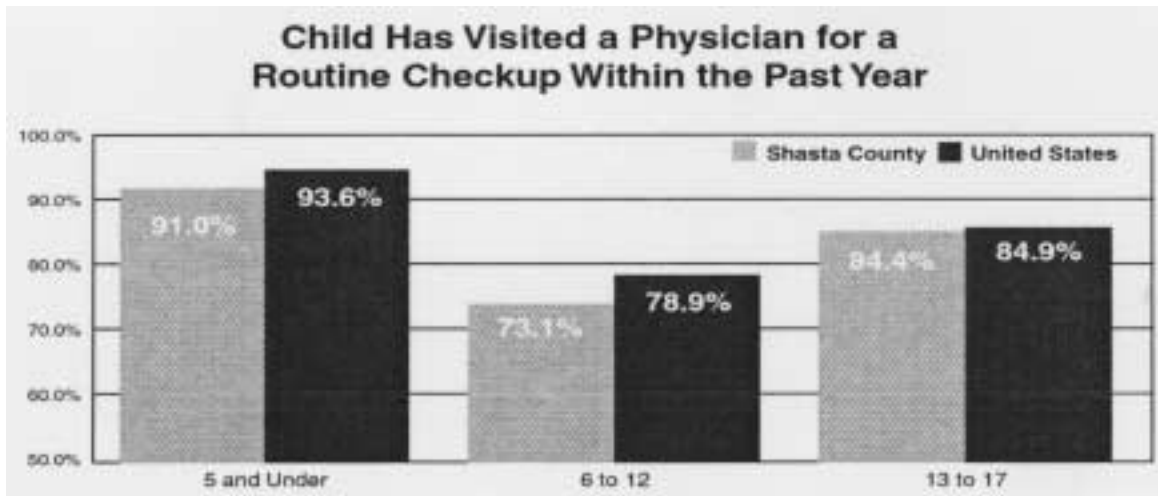
Estimated cost savings indicate that every \$1 spent on immunization saves \$10 in future costs.
LWV

An assessment done by the Department of Health Services of the immunization status of the 2,225 children enrolled in kindergarten in 56 schools in Shasta County in 1998 showed that 87.6% of these children had received all required vaccines, consisting of a minimum of 3 polio, 4 DTP/DTAP, 2 MMR, and 3 HBV, by kindergarten entry. Of all kindergarten students, 10.8% needed one or more immunizations, .09% had a medical exemption, and 1.48% had a belief/religious exemption. In comparison, 89.3% of the children enrolled kindergarten throughout California in 1998 received all required immunizations, and 9.7% needed one or more additional immunizations. MCAH

The following graph compares the percentage of Shasta County and California children up-to-date on immunizations by age 2

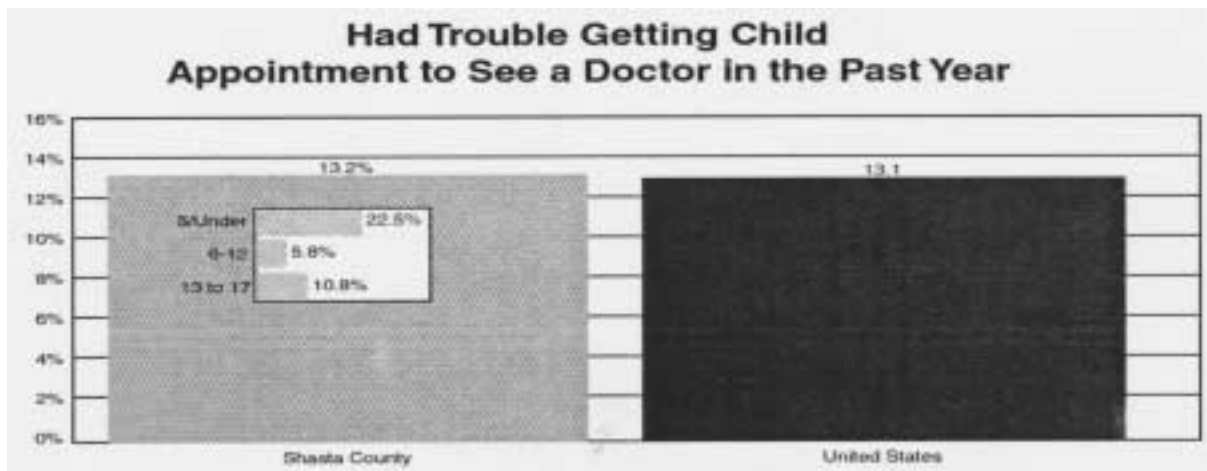


ACCESS TO HEALTH CARE

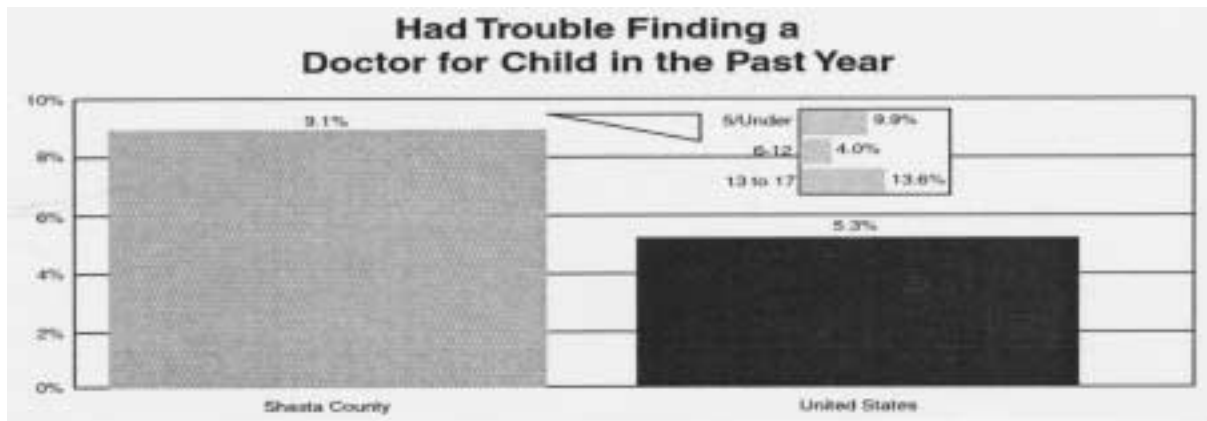


CHW/PRC

Note below that, in Shasta County, parents of children aged 5 and under much more often report difficulty getting an appointment than parents of older children.



CHW/PRC



CHW/PRC

CLINICAL PREVENTIVE SERVICES	Shasta Co.	US
% Cost Prevented Getting Child's Rx in Past Yr	7.8	4.4
% Difficulty Finding Dr for Child in Past Yr	9.1	5.3
%Cost Prevented Child's Care in Past Yr	9.6	7.3
%Difficulty Getting Appt for Child in Past Yr	13.2	13.1
%Child Has Had Checkup in Past Yr	83.1	85.6
%Inconv Hrs Prevented Child's Dr Visit in Past Yr.	13.1	16.3
%Transportation Prevented Child's Care in Past Yr	3.8	4.1

CHW/PRC

While there are a great deal more health services available for individuals using Medi-Cal insurance, an overwhelming sentiment among the families responding to our Shasta Head Start surveys was that the *services they receive are poor*. For many families, it is difficult ever to see the same doctor more than once so they are often explaining their medical issues every time they go to the doctor. They never really develop a personal relationship with a care provider and this is exacerbated by the amount of time that they're actually seen during their appointment. When they see a new person every time, they use up all their time trying to acquaint the person with their past medical history, leaving little time to address current medical issues and problems. SHS

HEALTH INSURANCE COVERAGE

Many low-income children whose families do not qualify for Medicaid are uninsured either because the parent's employer does not offer family benefits or because low wages preclude monthly co-payments for the more expensive family coverage plans. The State of California Access for Infants and Mother (AIM) is a new program providing low-cost health insurance. Shasta Community Health Center estimates that more than 30,000 Shasta County residents are without any form of health insurance. California Children's Services provides assistance with medical bills for children with catastrophic illnesses. LWV

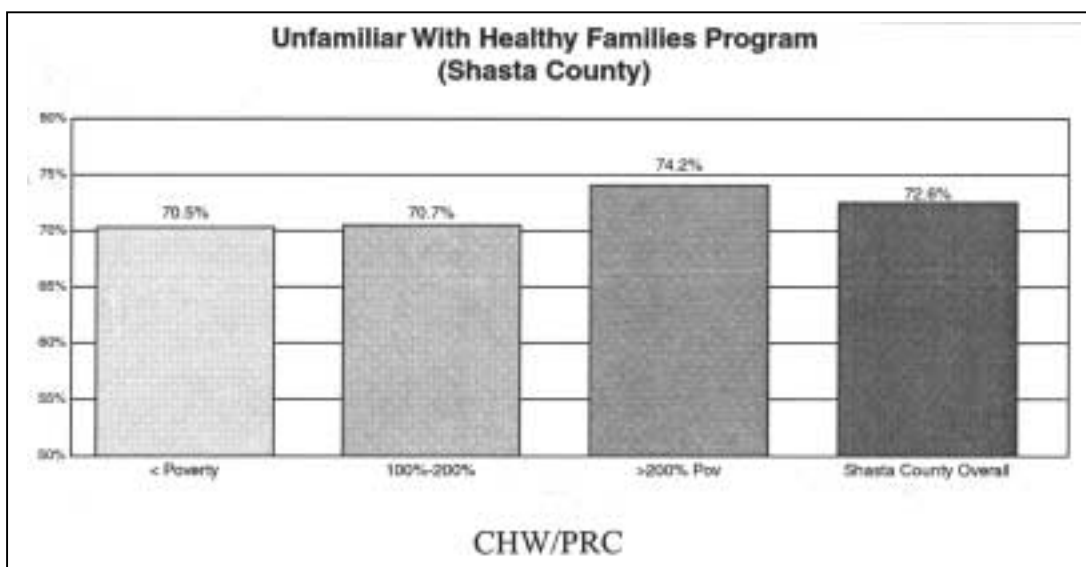
Medi-Cal: California has expanded the eligibility criteria to 200 percent of poverty level for Medi-Cal to pay for maternity care. The state has been able to do this through the use of federal options and state tobacco taxes. This expansion in Medi-Cal prenatal coverage has effectively decreased the number of women who were uninsured and increased the Medi-Cal prenatal coverage. In 1998, Shasta County had 33,447 individuals who were eligible for Medi-Cal, representing 20.1% of the population.

In the 1996 "Behavioral Risk Factor Survey" of 1,000 Shasta county residents, done by Public Health, 16% of all respondents said that they currently lacked any health care insurance coverage. Among those not covered, about one-third lost coverage in the past year, and about one-third have been without coverage for at least 5 years. Among all survey respondents, 59% said they were covered by private insurance or HMO's, 22% were covered by Medicare, 13% by Medi-Cal, and 5% by other types of health coverage (some were covered by more than one type of plan). Respondents under age 35 were more likely to lack health insurance coverage (27% more than those aged 35 and older). Respondents with annual household incomes under \$35,000 often lacked coverage, including 18% of those with incomes under \$10,000, and 27% of those with incomes of \$10,000 to \$20,000. MCAH

Many parents would prefer to purchase Healthy Families insurance even on their extremely limited incomes to ensure consistent, quality healthcare for their children and so they wouldn't have to endure the stigma that comes with being a "Medi-Cal" recipient. The biggest problem parents face with getting Healthy Families coverage is, they will not allow a family to enroll their children if annual income falls under Medi-Cal income guidelines. Second, Healthy Families only covers ages 0-19 of age, so even if our families did qualify nearly all of our parents would be left without any medical coverage. SHS

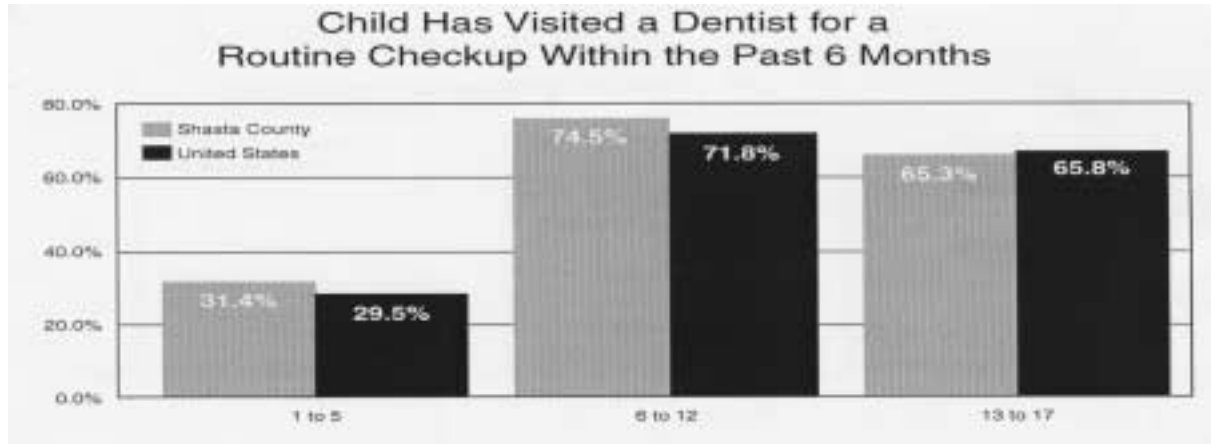
"The greatest insurance challenge faced in the county is the number of persons who are eligible for Medi-Cal but not enrolled in the program. Community members described that the enrollment process is perceived as demeaning. Both service providers and enrollees in the Healthy Families Program believe the challenges and "stigma" of the Medi-Cal program is extending to Healthy Families as well. SCHC

Familiarity with the Healthy Families Program, as shown below, 72.6% of area adults are not familiar with the program, including 70.5% of those living below poverty.



DENTAL CARE

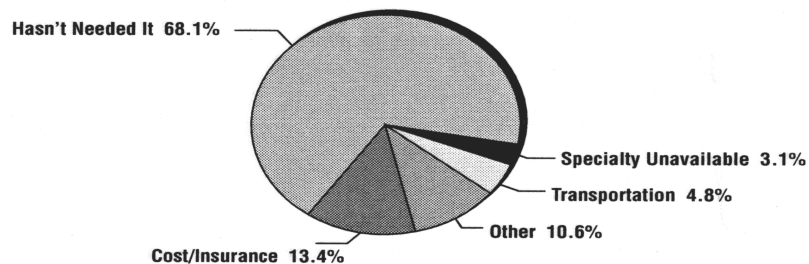
One significant barrier our families face in creating a medical home for themselves is the *lack of availability of dental services* for young children in particular and low income families in general. Dental services continue to be a serious need for many Head Start families as many of the children in our program are in serious need of significant dental care. There is only one pedodontist in Shasta County. Families have a difficult time finding dentists who will treat children under five and accept Denti-cal. SHS



CHW/PRC

Parents of children who have not had recent dental care were also asked to indicate the reason for this lack of care. As shown below, most (68.1%) said that their child **has not needed dental care**. Others cited **cost/no insurance/wrong type of insurance** (mentioned by 13.4%), **lack of transportation** (4.8%), and **lack of specialty availability** (3.1%).

Reason Child Has Not Had Recent Dental Care (Shasta County)



CHW/PRC

EARLY CARE AND EDUCATION

Cost of Childcare

The greatest need in Shasta County is increased funding for subsidized childcare for low-income families not eligible for CalWORKS assistance. Much of the recent economic growth in the county is in lower-wage service-sector jobs, which not only do not pay well, but have working conditions that strain parents' abilities to find stable childcare solutions. LCCPC

"Many more children are eligible for subsidized childcare but funds are not available to provide the service" LWV

Shasta County

CHILDCARE	1996	1997	1998
Cost/month – infant	\$425	NA	\$480
Cost/month – preschool	\$273	NA	\$361

CN

	Shasta Co. Ranking	# of Counties
Childcare cost/month – infant	14	38
CHILDCARE COST/MONTH	20	52

CN

Childcare Costs, Family Income	
Average annual cost of full-time, licensed care in a center, for an infant up to 24 months	\$5,873
Annual minimum wage of full-time worker	\$11,960
Care for an infant as a % of minimum wage	49%
Median annual household income in the county	\$32,612
Care for an infant as % of median income	18%
Care for two children as % of median income	32%

CCCR&R



Childcare Needs

Estimated % of children in care outside the family		
% ages 0-5 in care outside the family	51%	3,471
% ages 6-13 in care outside the family	20%	2,276

CCCR&R

Licensed Childcare Supply = 4,201 slots	
68% of all slots are in childcare centers	
Up to 24 months	4% of center slots
Ages 2 – 5	63% of center slots
Ages 6 and over	33% of center slots
32% of all slots are in family childcare homes	
Children Needing Childcare = 18,187	
Children with working parents	
Ages 0 – 5	6,807 children
Ages 6 – 13	11,381 children
Licensed childcare supply meets only 25% of the estimated need for licensed care for children of all ages. There are 4.3 times more children, ages 0 – 13, with working parents than licensed childcare slots	
Shasta County ranks 32 nd among California's 58 counties in its supply of licensed childcare slots, as represented by this ratio	

CCCR&R

As of September 1999, there were 37 children (ages 18 mos-3rd birthday) and 16 children (ages 3-5) on the Children's Center Program Waiting List. As of September 17, 1999 there were 40 children (ages 3-5) on the State Preschool Waiting List. LCCPC

Head Start

It has been estimated that for every dollar spent on the Head Start program, seven dollars will be saved from participants staying out of prison and graduating from high school. There is a commitment to best practices in child development, education and family advocacy. A vital component is transition to Kindergarten. The availability of space, transportation and money affect the number of children served. LWV

Shasta County

CLASSROOMS	1996	1997	1998
% eligible in Head Start	NA	38.0%	NA
Average class size	27.6	26.2	25.8
Per pupil expenditure	\$4,144	\$4,629	\$4,994

CN

	Shasta Co. Ranking	# of Counties
Percent of eligible 3-4 year olds in Head Start	52	57

CN

Childcare Requests to Shasta Co. Resource & Referral (R&R)

TYPE OF CARE REQUESTED	
Infant/toddler care	36% of calls
Preschool care	39% of calls
School-age care	25% of calls
Family childcare homes	90% of calls
Childcare centers	24% of calls
In-home care	1% of calls
<u>SCHEDULES REQUESTED</u>	
Full-time care	42%
Part-time care	62%
Before-and/or after-school care	18%
Full-time care, children 0-5	47%
Part-time care, children 0-5	57%
COMMUTING SCHEDULES	
Workers outside the home commuting to work between 5 a.m. and 10 a.m.	79%
Workers leaving home after 10 a.m. for swing or night shifts	21%
REQUESTS FOR CARE DURING NON-TRADITIONAL HOURS	
Evening, overnight, or weekend care	11%

CCCR&R

"...the whole county is in need of daily care for all children from 7:30 a.m. until 6:30 p.m.; after hour and weekend care for those families who traditionally work in food service occupations, retail stores, some medical and businesses that traditionally stay open until late evening." LCCPC

Agencies which provide care for sick children or 24-hour care for parents working evening and night shifts are non-existent in Shasta County. LWV

There are not 24-hour a day childcare centers available for workers with irregular work schedules, nor are there any centers for sick or recovering children. LWV

The R&R has received an increasing number of calls from parents seeking referrals for children with mental health issues and special needs. Currently there aren't enough trained providers to

accommodate these children. The R&R is also trying to recruit more Spanish-speaking childcare providers and to attract providers to serve rural pockets of the county. CCCR&R

Infant care

"...the demand for infant/toddler care far outstrips the availability of childcare." SHS99

Childcare centers	1996	1997	1998
% spaces for infants	3%	NA	4%

CN

	Shasta Co. Ranking	# of Counties
Childcare: % spaces for infants	26	47

CN

Licensed Childcare Supply			
Facilities	1996	1998	Change
Childcare centers	51	62	22%
Slots for infants	66	116	76%
Slots for ages 2-5	2,068	1,792	-13%
Slots for ages 6 and over	431	931	116%
Family childcare homes	161	150	-7%
Slots for all ages	1,428	1,362	-5%
Schedules offered			
Of <i>all</i> slots in licensed childcare centers			
Full-time and part-time	76%		
Only full-time available	3%		
Only part-time available	21%		
Of <i>all</i> slots in licensed family child care homes			
Full-time and part-time	83%		
Only full-time available	13%		
Only part-time available	4%		
Centers with before/after school care			56%
Homes with before/after school care			73%
Care available during non-traditional hours			
In licensed and license-exempt centers			0%
In family child care homes			35%

CCCR&R

Our rural geography also means that because needs are so dispersed, it can be difficult to make center-based care financially viable. E.g. Burney, Fall River Mills: this isolated area also offers few opportunities for residents to take ECE classes or pursue other professional development activities. ...few residents are educated about the advantage of quality childcare and so have not raised any demand for it. SHS99

Salary of childcare worker	\$16,140
Salary of preschool teacher	\$20,090
Salary of entry-level public school teacher	\$23,835

CCCR&R

Community members cited that there were not enough day care resources in the county to meet the needs of those in the CalWORKS program. SCHC

The dominant trend resulting from the implementation of CalWORKS over the last year is in the area of childcare. An unexpectedly large percentage of childcare for newly working parents in the catchment area is being conducted by unlicensed childcare providers. This trend, although unexpected, makes sense from the perspective of low-income individuals in that federal-and state-generated childcare provider dollars flow directly to the family and acquaintances of the individual seeking childcare, particularly since licensed childcare is so expensive relative to the working poor's incomes and there is a shortage of slots available through subsidized programs such as Head Start. In many respects, the use of childcare dollars to increase extended family incomes is a positive development, however, the issues of monitoring the quality of childcare provided and providing proper training of childcare providers then become crucial. If this trend continues, a major responsibility of Shasta Head Start and other childcare agencies and educators will need to include assuring that unlicensed childcare providers are adequately trained and supported in their activities. SHS99

CHILDREN WITH SPECIAL NEEDS

The state average for birth defects is 29.1 per 1,000 births. Shasta County is above average in 1992 with a rate of 35.9 per 1,000 live births. LWV

As of April 1999, there were 3,003 children with an IEP or IFSP in Shasta County: 448 were under the age of three, 275 were ages 3-5. LCCPC

In December 1998 there were 450 children, birth to kindergarten age with special needs. LCCPC

An area of concern in Shasta County is the number of over-income families with seriously disabled children who do not qualify for county programs. When there are no more over-income slots available in Shasta Head Start, there are presently no other programs available for these children. SHS99

A significant area of concern identified in the area of special needs is the virtual nonexistence of service for deaf individuals. SHS99

Needs of the agency and future goals include: assisting children who have significant behavior issues but do not qualify for special education according to SELPA guidelines; children with sensory integration impairments and lack of services to them; as well as quality parent education classes available. SHS

CHILD SAFETY

Shasta County

MOTOR VEHICLE INJURIES & DEATHS (1998)	Ages 0-17	Ages 0-5
Injuries	311	39
Deaths	4	1

CN

	Shasta Co. Ranking	# of Counties
Vehicle injuries & deaths (0-17)	27	55
Vehicle injuries & deaths (0-5)	24	44

CN

	Shasta Co.	US	Healthy People 2000
% Child (<5) "Always" Uses Auto Child Restraint	100	98.9	95

CHW/PRC

MATERNAL EDUCATION LEVEL

In Shasta County in 1992, 65.9% of infants were born to women who had completed twelve years of education or less - similar to the percentage of 64.7% for the State; only 9.9% of infants were born to County residents who had completed sixteen or more years of education compared with 15.6 percent for California overall. This means in Shasta County that only 1 in 10 babies are born to women with a bachelor's degree. MCAH

Shasta County

BABIES BORN TO MOTHERS WITH <12 YRS. OF EDUCATION (1997)	Number	Percent
All	453	22.7%
African-American	8	34.8%
Asian	11	19.6%
Latino	59	41.8%
Native American	26	29.5%
White	348	20.6%

CN

	Shasta Co. Ranking	# of Counties
Mothers w/<12 yrs education	20	55

CN

POVERTY

Shasta County

CHILDREN LIVING IN POVERTY (1995)	Children Ages 0-17	Children Ages 0-4
Percent	24.0%	27.6%

CN

	Shasta Co. Ranking	# of Counties
Children living in poverty (0-17)	35	58
Children living in poverty (0-4)	39	58

CN

Children who grow up in poor families are more likely to go without necessary food and clothing, lack basic health care, live in substandard housing and have unequal access to educational opportunities. LWV

Poor children are at greater risk of being born with low birthweight, dying in infancy or childhood, having health problems that affect school performance, becoming a teen parent and dropping out of school. MCAH

Low income is consistently correlated with a lack of early and adequate prenatal care. LWV

Although most children live with two parents, over one-fourth of Shasta County children lived in a single parent household in 1990. The increase in single parent families over the past three decades has occurred across all races and income levels. Single parents with limited education are at increased risk of social and economic problems. When the single parent is a woman, the risk of the family falling into poverty is greater due partly to wage gap between women and men, and the high rate of uncollected child support. LWV

Through February 1999, an average monthly total of 18,253 individuals, approximately 11% of population, were receiving TANF benefits. The maximum monthly benefit for a family of four in Shasta County is \$693. MCAH

Shasta County

CHILDREN RECEIVING TANF (1998)	Percent Ages 0-17	Percent Ages 0-4
All	22.2%	27.2%
African-American	47.1%	78.4%
Asian	51.0%	37.6%
Latino	10.8%	15.1%
Native American	28.3%	29.1%
White	21.3%	27.2%

CN

	Shasta Co. Ranking	# of Counties
Children receiving TANF (0-17)	45	58
Children receiving TANF (0-4)	47	58

CN

The transition from welfare to work

Families cycle on and off the welfare rolls, periodically taking low-paying jobs which do not raise them above the poverty level. Barriers to sustainable employment include low wages that do not provide for transportation, child care and family health insurance. Education, job training programs and job placement assistance increase the possibilities for obtaining a good job with a livable wage and the potential for advancement. LWV

TRANSPORTATION

"The rural nature of the county and lack of public transportation makes it more difficult to access care for some segments of the community." LWV

"The cost required to travel great distances and perceived inadequate and inconvenient public transportation creates challenges for people trying to access medical or other services" SCHC

"The scarcity of public transportation severely limits accessibility of childcare for many families. While a number of agencies and schools are trying to address this by developing programs in outlying areas, center-based care generally lacks the flexibility that family care providers can offer..." LCCPC

Lack of adequate transportation is the number one problem identified by Shasta Head Start parents in our surveys. Some rural areas have no public transportation whereas that provided in other areas is inconvenient, often costly, and doesn't service most of the areas where our families live. SHS

As Head Start families move from TANF into the work force, transportation creates one of their most difficult challenges. This is particularly true for families living in the rural parts of our catchment area, but it is also true to a lesser degree for families living in our more urban centers. SHS

MENTAL HEALTH

It was found that children six years and under are in the greatest need of (mental health) services. Systematic and early identification of children who need services, and access for all are vital. LWV

Mental health services for children, homeless adults, and the developmentally disabled were mentioned most frequently...as areas of great need. SCHC

Very few programs will see children ages 0-5 because they don't have Mental Health professionals with a background in early childhood. *Where affordable limited services are available or Medi-Cal accepted, the process for getting a child in to receive counseling can be long and difficult for our families.* At some of these agencies, the necessary paperwork and assessments to get services to a child can take several months. Other agencies that are affordable and who will see children have specific mental health criteria that a child and family must meet in order to receive services, not all families meet those criteria. SHS

Affordable Mental Health services for adults can also be difficult to access. Some agencies will see adults quickly if they are covered under Medi-Cal but many adults are uncomfortable with the level of services provided, such as group counseling or a different counselor each time they attend – Much like receiving medical services under Medi-Cal. There are a few agencies that provide payment on a sliding scale and will see both children and adults, but, these scales almost always have a bottom minimum that does not make services affordable for our economically challenged families. SHS

Med-Cal has recently implemented a managed care program for mental health. At any one time, 17,000 persons in Shasta County are eligible for Medi-Cal, any of which may need mental health services. Previously, 4,000 persons were being served by the county mental health program. County mental health system providers and leaders indicated that the county may not have the capacity or resources to address the needs of the Medi-cal population under managed care. This resource challenge has an impact on other providers in Shasta County that care for this same population. SCHC

FAMILY VIOLENCE/CHILD ABUSE

The Impact of Domestic Violence on Children

Between 15-25% of women are battered during pregnancy. Battering causes damage and distress to the fetus. The baby's developing brain and tender nervous system may be over-stimulated repeatedly by the mother's fear and adrenaline. A strong jolt of fear can send convulsion-like tremors through the fetus. Such energy often surges through the baby's brain at the very time when crucial nerve connections are forming. In homes where domestic violence occurs, children are abused at a rate of 1,500% higher than the national average. LWV

1,170 children (282 ages 0-23 months, 287 ages 3-5, and 601 ages 6-13) received domestic violence related services from Women's Refuge (October 1998-September 17, 1999, not including services in Eastern Shasta County). LCCPC

Child Abuse

The average age of child abuse victims in California in 1993 was 7 years old. About 41% of the children are 5 years or younger. LWV

In 1996, there were 139 referrals for investigation of child abuse and neglect per 100,000 children in Shasta County. For the same year, the California child abuse/neglect referral rate was a lower 75 per 100,000 children. CHW/PRC

There were 4,548 disposition of referrals of suspected child abuse/neglect made to CPS (FY 1998-99). LCCPC

605 children received services from CPS in Shasta County (FY 1998-99). LCCPC

Trending over the past decade suggests that the rate of child abuse in Shasta County is fluctuating, but does not show a clear increasing or decreasing trend. CHW/PRC

Shasta County

CHILD ABUSE (1996)	
Number of reports	6,337
Rate (per 1,000)	146.3

CN

	Shasta Co. Ranking	# of Counties
Children abuse	48	58

CN

"Both Shasta county community health panels identified family violence, particularly spousal and child abuse, as a pervasive area problem that should remain a top priority in health improvement efforts." CHW/PRC

SUBSTANCE ABUSE

"All agencies interviewed listed drug and alcohol abuse as one of the most significant factors leading to family chaos and the resulting need for public assistance." LWV

"Key community health issues include drug abuse and domestic/family violence." SCHC

As of September 27, 1999, 116 children's parents were receiving services from the Shasta County Drug and Alcohol Perinatal Program. LCCPC

Overall, illicit drug use rates among childbearing women appear to be higher in the northern part of California than in the rest of the State. The 1992 "Perinatal Substance Exposure Study," which included childbearing women in Shasta County in its Northern California region, showed 6.1 percent positive tests for illicit drug use. Of these tests, positive prevalence was 4.4 percent marijuana, 1.4 percent amphetamines, 2.6 percent opiates and 0.4 percent cocaine. HIP

At the Mercy Maternity Clinic, in the first nine months of 1997, there was an average of 11 positive methamphetamine tests per month. This compares to an average of 2.125 positive tests per month in 1991. LWV

Alcohol

The 1992 "Perinatal Substance Exposure Study," performed by the Office of Perinatal Substance Abuse, California Health and Welfare Agency, showed that 6 percent of childbearing woman in 14 Northern California counties tested positive for alcohol at the time of delivery of their infants. The statewide California estimate for use of alcohol preceding delivery was 6.8 percent of childbearing women. HIP

TOBACCO USE

Tobacco use remains the single-most avoidable cause of death in our society. The predominant form of tobacco use is cigarette smoking, which has been associated with coronary heart disease, cancer (of the lung, larynx, pharynx, oral cavity, esophagus, pancreas and bladder), stroke, emphysema and other health problems such as respiratory infections and stomach ulcers. CHW/PRC

The 21.3% prevalence of smokers recorded in Shasta County (1999) is similar to the 22.8% prevalence recorded nationwide, but does not satisfy the *Year 2000* goal to reduce smoking prevalence to 15% or less of adults aged 18 and over. California residents report an 18.4% smoking prevalence. CHW/PRC

18.9% of women and 23.7% of men currently smoke, (1999) either regularly or occasionally. By analysis, a 23.5% prevalence of cigarette smoking is noted among women in their child-bearing years (ages 18-44). This is notable, given that tobacco use increases the risk of infertility, as well as the risks for miscarriage, stillbirth and low birthweight for women who smoke during pregnancy. The *Healthy People 2000* goal for the subset of women aged 18 to 44 is a prevalence of less than 12% smoking by the year 2000. CHW/PRC

In examining cigarette smoking by education levels, a negative correlation is evident; smoking prevalence levels are lowest among the groups of community residents with the highest education classifications. Note that *Healthy People 2000* sets a goal of less than 20% smoking by the year 2000 for individuals with a high school education or less. CHW/PRC

A similar, negative correlative relationship is seen with income. Those at lower income levels show the highest prevalence of cigarette smoking; this decreases dramatically as income rises. CHW/PRC

Second-hand smoke

The dangers of smoking are not limited to the smoker alone. Passive or second-hand smoke can cause disease (including lung cancer) in nonsmokers and severe respiratory and other problems in young children and infants. CHW/PRC

16.9% of households with children in Shasta County have someone who smokes in the house. CHW/PRC

Perinatal Tobacco Exposure

Smoking during pregnancy is closely associated with an increased risk of infant mortality. Some of the increased risk is due to the relationship of smoking to higher rates of low birthweight, sudden infant death syndrome (SIDS) and pre-term labor. HIP

Smoking rates among Northern California pregnant women in 1992 were more than double the statewide rates and double the *Year 2000* National Objective. In 15 Northern California counties in 1992, 21 percent of pregnant women reported that they smoked during pregnancy, compared with 8.8 percent of pregnant women statewide. HIP

COORDINATION OF SERVICES

"Responsibility rightly belongs with the parents and families, but the community – governing bodies, agencies, law enforcement, educators, businesses, churches and citizens – needs to be involved so that all children will have the resources to grow up to become useful citizens." LWV

Agencies must select and agree upon indicators which best reflect the condition of children. Each agency must then collect statistics relevant to those indicators. LWV

Throughout the study we were troubled by inconsistencies in the timeframe, format and types of statistics maintained in some instances, and the lack of statistics in other instances. Without clear, accessible information, it is difficult for the public to understand and accept responsibility for conditions in their communities, and for public officials to make informed decisions. LWV

We can tell you how many families in Shasta County receive Food Stamps and/or AFDC and how many children receive free and reduced-price meals at schools. We can't tell you how many children go to bed hungry. We can tell you how many cases of child abuse and neglect are reported to Child Protective Services. We can't tell you how many go unreported or how many children to bed scared. We can tell you how many children stayed at the homeless shelter and at Women's Refuge. We can't tell you how many children don't even have a bed. We can tell you how many children are enrolled in school on any given day. We can't tell you how many are taken out of one school and aren't immediately enrolled in another school. LWV

When this study began, gaps seemed to exist in the area of child counseling, mental health crisis counseling, and residential treatment and diversion programs, including substance abuse. Recently, several agencies and school-related programs have received substantial grants to help fill some of these needs. LWV

While interviewing agencies and organizations which are the conduits for providing services to the county's at-risk population, we also received an education about how many other people benefit from such programs. Some of the county's largest payrolls result from state and federal financing for these programs. LWV

The numbers of people served and the amount of money which comes into the county were a revelation. With block grants, local fund raising, private grants and state and federal funding, millions of dollars come into Shasta County each month to provide services for children and families. Even so, the lack of stable funding is a problem for many, if not all agencies. Many agencies reported that staff shortages and turnovers are a result of funding uncertainties. LWV

Agencies must carefully assess the likelihood for further funding when considering seeking a grant. Grants are important funding sources for many agencies. Valuable agency resources are expended on the grant process – writing, audits and evaluation, locating and furnishing facilities, hiring and training staff, etc. Problems arise when the grant money runs out and alternative funding is unavailable. Valuable programs may simply disappear. LWV

Some agencies mentioned the lack of local control over programs for which the agency is funded. In most cases money is designated for programs designed by entities far removed from our local situation and do not allow for flexible implementation to meet local needs. LWV

Existing programs and providers should be utilized before establishing new ones. Every effort should be made to utilize agencies which are already successfully providing services before creating new bureaucracies for similar programs. For example, if a community wishes to establish a program for safe and sober activities for youth and families, it should first contact agencies such as the YMCA which has a proven record for successfully providing such programs. Whenever possible, programs should be consolidated to prevent competition for the same grant monies. LWV

All agencies, including schools, should continue to strive to communicate and cooperate. LWV

Whenever possible a case management system, in which a family is guided through the system with continuity, should be established. This would ensure that families are being referred to all appropriate services, and that the family's progress, changing needs and compliance are being monitored. LWV

Legal constraints to sharing confidential information can be a barrier to a collaborative effort to serve the at-risk child. Agencies should continue to work together to find ways to facilitate the sharing of pertinent information among appropriate professionals in order to provide a family with the most comprehensive and cost effective service. "Turf" protection or a non-cooperative attitude has no place in providing for the needs of children. LWV

We are very concerned about the effective use of public money in improving the well-being of our children. In order to evaluate the effect social programs have in changing people's lives and bringing about changes in the social condition, there must be some evaluation mechanism other than documentation of the number of clients served or the number of programs delivered. Agencies must develop program evaluation tools which provide qualitative as well as quantitative data. These data should include information on the long-term effect of programs. LWV

It is recommended that the Children's Policy Council be expanded to include a representative from law enforcement, the private health community, and representative from the six regions identified within the study. CAPC

Given the changes in the public mental health system, local changes in public health, and the fiscal priorities of the county, the site visit team observed that SCHS has stretched itself to provide a broader range of high-quality services, such that the successive gaps that have been created from shifts in these other systems has gone largely undetected by other service providers, or persons in need in the community. The county must continue to play an important strategic and supportive role to non-profits that are filling these service gaps. This includes considering low local, state and/or federal resources, tied directly or indirectly to care for disadvantaged residents of the county, support those organizations who provide direct health services to at-risk residents of the community. SCHC

Shasta County has a history of collaborative problem solving, particularly around health issues, and the county is beginning to see collaborative efforts that are paying dividends

1. The Healthy Start partnerships
2. The Health Improvement Partnership
3. The Anderson Partnership for Healthy Children. SCHC

OTHERS' CONCLUSIONS/GOALS

“The agencies we visited stated that drug and alcohol abuse is a major problem in Shasta County. This plus the lack of jobs, poverty, inadequate parenting skills, domestic violence and dysfunctional families create children who are at risk.” LWV

Based on their (study), the Children’s Policy Council recommended that providers focus on families of young children, 0-5 years of age. Among critical services needed to support the development of children in this age group were: case management, child development, mental health, health information, substance abuse prevention, child care and recreation and enrichment. CAPC

The following recommendations are made by the Children Policy’s Council:

To create a program that supports families by teaching them how to provide consistent, healthy care for children in order to develop the readiness needed to participate and be successful in school and the community. Support for young children does not merely refer to establishing preschools or infant classes. It refers to all the activities and interventions which address the needs of young children and help them to strengthen the contexts in which they are embedded:

- a) establish a home visitation program that emphasizes the health and well-being of children and families...to mothers and/or families of children under the age of 5 years whose families are enrolled in CalWORKS.
 - b) establish a neighborhood based, home visitation program that is coordinated with existing groups
 - c) target families that are currently receiving CalWORKS who have children 0 to 5 years of age
 - d) staff will be trained in the various resources available in the community CAPC
-

We encourage the establishment of more parenting programs and both youth and family mentoring programs. LWV

Increasingly, agencies are having to deal with more than one generation in dysfunctional families. Parents need to learn how to be parents – from how to budget to how to effectively discipline children. LWV

The number of children who are victims of violence in Shasta County is intolerable. As a civilized society, we must find the abuse of even one child unacceptable. We must support efforts to eliminate violence in all forms. LWV

We would like to point out that any child can be at risk, regardless of his or her economic situation. Child abuse, drug and alcohol abuse, mental health disorders and other problems cross all socio-economic lines. LWV

The importance of education must be a principle embraced by the entire community.

- Many times, school is the first place children's problems are identified, and too often it is the only place a child feels safe.
- Education is an important key to breaking the cycle of poverty and dependence upon social services. LWV

We must not lose sight of the fact that a parent or caregiver who is ill or in need of counseling adds to the problems of the at-risk child. This can be a significant factor to a child's school attendance. LWV

As a community we must always be concerned with the quality and affordability of child care as well as the availability.

Child care is an issue basic to the economic well-being of a family. If parents are to work and provide for their families, someone must care for that family's young children. Agencies which provide care for sick or 24-hour care for parents working evening and night shifts are non-existent in Shasta County. There are many fine programs designed for "latch key kids," some located at school sites. The Shasta County Office of Education has a child care referral program. Welfare reform legislation will provide funding for even more child care facilities. Communities and families would benefit from affordable child care placed at or near worksites. LWV

Shasta County MCAH Local Plan

The following needs were identified as health concerns for the Shasta County maternal, child and adolescent population

1. Reduce the infant mortality rate to no more than 7 per 1,000 live births
2. Decrease the number of deaths and injuries due to motor vehicle crashes to Shasta County young children (0-5) and youth ages 15-19.
3. Increase breastfeeding duration rate.
4. Increase access to comprehensive and appropriate preconception and interconception care for women of childbearing age in primary care settings.
5. Reduce child abuse and neglect in Shasta County children.

Shasta County Maternal Child Health Program has identified two goals/objectives for the local five year plan. These two goals are:

1. Increase breastfeeding rate and duration to at least 75% the proportion of mothers who initiate breastfeeding and to increase to at least 13% the proportion who continue to breastfed until their infants are 6 months old.
 2. Community members will increase their knowledge and involvement in the prevention of family violence. MCAH
-

Wide dissemination of information regarding affordable services for children would be helpful for the community. LWV

Agencies must keep the public and other agencies informed as to what services they provide. For example, California now has low-cost medical insurance programs available for low-income families. The Access for Infants and Mothers and CalKids programs were recently created to serve these families, yet many of those eligible are unaware of their existence or do not have the information necessary to access them. LWV

Health care is available through Medi-Cal, Child Health and Disability Prevention Program, Mercy Family Health Center, Mercy OB Clinic, Shasta Community Health Center, Pit River Health Service, Family Planning, Redding Rancheria, Hill Country Community Clinic, Women's Health Services, Public Health Immunization Clinic and many private clinics and physicians. Some school districts have received grants to help with health care and other needs of at-risk children. LWV

Given the scope of medical services available to children in our county, it is appalling that any child would lack medical attention. LWV

More family counseling, mental health crisis counseling, residential treatment and diversion programs, including substance abuse diversion programs for children are needed. When parents find these services, the cost is prohibitive unless the child is referred by a public agency, such as Child Protective Services or Far Northern Regional Center. Few private counselors accept Medi-Cal patients. LWV

Help for the younger child and the family will go a long way to prevent the at-risk problems we see later. LWV

Shasta Head Start Goals, 2000-01

An important goal for our agency will be to partner with any and all agencies and individuals in the three-county area who can help us create convenient, affordable, safe child care opportunities that meet the varied and growing needs of families in our catchment area. The range of possible partnerships includes establishing wrap-in, wrap-around child care programs in tandem with county offices of education as well as individual school districts, and incorporating licensed and exempt child care in our home-based program, to create a network of well-qualified child care providers knowledgeable about developmentally appropriate needs for children between the ages of zero and five. SHS

As the percentage of non-English speakers increases in our catchment area, there is an ongoing need for the availability of qualified translators and interpreters, as well as an increased need for Head Start social services staff to work with these individuals in providing services to non-English speaking families. SHS

<p>Another goal will be coordinating with county and local agencies who also provide transportation in a way that helps our families to successfully further their education, enter the work force, and get their kids to school and health care appointments. SHS</p>
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"HOW ARE THE CHILDREN?"

APPENDIX C

Shasta Children and Families First Commission

SUMMARY: COMMUNITY FOCUS GROUPS

COMMUNITY FOCUS GROUPS

Twenty-one community focus groups were conducted, March 15-May 4, 2000.

In all of our focus groups, participants have offered thoughtful and heartfelt insights into the community and how it addresses the important prenatal to 5 year old period. Parents and providers alike have engaged openly and with candor as they contributed their experiences and observations in hopes of creating a community in which young children and their families are placed as a priority. Interest in and enthusiasm for our work has been apparent and serve as sources of inspiration for us to fulfill our mission and obtain our vision.

Parent Groups

Sixteen focus groups were with parents of children 0-5 years old. These groups were strategically selected to ensure input from various segments of the community considering geography, family income, family composition, ethnic affiliation, age of children and age of caregiver. In most cases, participants were invited to attend by a person or program with which they were familiar through the use of fliers, newsletter articles, personal phone calls and personal contacts. Additionally, paid advertisements and news articles appeared in both intermountain newspapers. Meeting times were set to best meet the schedules of potential attendees. Meals or refreshments were provided to most groups; child care was provided when necessary; language translation and a prize raffle were available for parents from the Southeast Asian community; transportation was provided to parents in the Anderson Head Start meeting; and travel reimbursement/ stipends were paid to Foster Grandparents by that sponsoring program. A total 96 parents/grandparents participated in these groups.

Provider Groups

The remaining five focus groups were with service providers. Two of these groups, one in Redding the other in Burney, were multi-disciplinary and by direct invitation. Attendance in these groups was 29 and 19, respectively. They were comprised of professionals working in the fields of medicine, health care, social services, mental health, education, early care and education, and early intervention. A third multi-disciplinary meeting was with 10 advocates/interpreters who work with parents in the Latino Community. The two other provider meetings were with 14 members of the Family Child Care Provider Association and 20 staff members of the Family Health Division, Shasta County Department of Public Health.

SUMMARY OF COMMUNITY INPUT

A consistent format and approach was utilized in all community focus groups. All groups were attended and facilitated by the SCFFC Executive Director, except for the group in Oak Run, which was attended and facilitated by the SCFFC Program Assistant. Notes were taken of the input received at all focus groups and the info received is summarized in this report. Half of the focus groups were attended by 1-3 SCFFC Commissioners.

In all groups, an overview of the purpose, structure and desired results of the California Children and Families Act was offered as was a description of the Shasta Commission. Emphasized was the local Commission's focus on prevention and early intervention and its intention to seek long-range attitudinal and behavioral changes throughout the community – changes that would demonstrate the value of the prenatal-to-5 year old period. Within this framework, participants were asked for their input into how the local Commission can best use its resources to develop stable families and healthy children who are ready to learn. Participants in the multi-disciplinary provider groups also were asked to describe a vision of a community which values the young child and is characterized by an integrated service delivery system.

Responses were received with regards to what already is working, gaps in service delivery and ideas about additional services that would be useful. Through these conversations, participants often offered insight into strategies for implementing these ideas, observations about existing community attitudes, and ideas about creating community attitudes more reflective of the importance of early childhood. In some instances, visions of a community that places *children and families first* materialized.

What follows are observations offered by community members about 1) community attitudes which would be supportive of healthy young children and the stability of their families and 2) needed services/systems/programs that would promote the development of safe, nurturing environments for young children.

DESIRED COMMUNITY ATTITUDES: RELATED THOUGHTS AND STRATEGIES

Eight attitudinal themes supportive of healthy young children and the stability of their families emerged through our focused conversations with members from varied segments of the community. These attitudinal themes follow:

1. A community measures its well-being by the well-being of its children

How Are the Children?

“It takes a community (*a village*) to raise a child”

< communicate: *kids need someone to take a personal interest in them*

< neighbors need to be involved with the children in their neighborhoods

< every adult has the responsibility to be a good role-model for children

< kids *copy being good* – it's the community's responsibility to model *good*

< “we all are responsible for the community”

< businesses and employers needs to be involved in supporting family-friendly practices

< all community members, of all ages, need to be involved in the community

< linkages between young children and the elderly need to be created

< normalize behavior in which adults in a community know and help each other and their children

< encourage community members, service providers, community leaders, etc. to act as *grandmas*, i.e. as outreach workers to children

< create community/parent expectations that young children will go on to get a college education

2. Good parents ask lots of questions . . . about everything

- < *communicate that it's a sign of good parenting to want information, ask questions, and seek support*
- < encourage parents to seek help and information
- < support and inform parents who express concern and ask questions
- < eliminate references to concerned parents as being *paranoid and nervous*
- < listen respectfully to parent questions and concerns
- < communicate: we all need help raising kids
- < offer encouragement for parent assertiveness and advocacy on behalf of their children
- < encourage parents to seek second opinions
- < develop a media campaign to encourage seeking information
- < eliminate the assumption that because a parent is *in the system* s/he is receiving all of the services available or needed by the family
- < develop a media campaign to increase awareness of resources: *are you caring for young children? These resources are available . . .*
- < have MDs assign prenatal and new parents to become involved with or to investigate parenting resources and information between visits

3. Male involvement in all aspects of parenting is the norm

- < emphasize importance of dad/child bond
- < encourage male involvement in prenatal visits, childbirth and childrearing
- < encourage dads to play and interact with their children
- < portray male role-models and leadership in parenting activities
- < make this a political agenda among political figures
- < educate service providers re: importance of father/child bonding
- < offer *daddy and me* classes
- < offer groups for stay-at-home-dads
- < offer *father/son nights*
- < solicit father opinions and expertise

4. Breastfeeding is the norm

- < eliminate assumptions that moms who are young and/or poor will not breastfeed
- < acknowledge: *even moms with premature, early deliveries can breastfeed*
- < develop an information campaign to convey the benefits and advantages of breastfeeding for the mom and the baby
- < present images of breastfeeding moms in ads, other media
- < encourage businesses, etc. to post signs: *breastfeeding mothers are welcome here*

5. Parenthood is an important, exciting and prized job

- < create acceptance for stay-at-home parents
- < strive for a local government which makes children and families a priority
- < “parents that take good care of themselves are better parents”
- < “practice self-care”
- < “take a break - it’s normal to be stressed”
- < acknowledge parents as experts about what their children need

- < educate providers to ask, not tell, parents about their children
- < accept that parents want to raise children as good human beings
- < *convey the importance of parenting and prenatal care by encouraging MD offices to send prenatal information to women unable to schedule a timely appointment*
- < offer parenting and family life curricula in schools

6. Play is the work of children

- < make learning fun
- < emphasize playing with children
- < develop commercials/ads/PSAs re: reading and playing
- < communicate: *take time to play*
- < promote the concept that *play is the building block of learning*
- < promote the concept that *it's the fun stuff that allows them to learn*
- < have many parks, playgrounds and recreational activities available
- < promote the concept that babies prefer people to TV

7. Cultural diversity is appreciated and beneficial

- < strive to combat racism
- < communicate: *it's normal to be different*

8. A child with a special need is just a typical kid

Educate the community about appropriate responses/interactions with children with special needs

- * *ask, don't stare*
- * treat children with special needs normally – don't give them sympathy
- * don't overcompensate with kindness – encourage their self-reliance
- * don't touch children without asking

SUGGESTED STRATEGIES FOR CHANGING ATTITUDES

Appeal to *enlightened self-interest* –

Children are an investment in our future

Build community consensus around the well-being of children 0-5

Develop common goals with families, agencies, businesses

Lobby/advocate at the local level

Provide lots of education: in homes and throughout the community

Utilize media, articles, feature stories, news columns

Conduct public service campaigns

Create bumper stickers and badges

Utilize media spots for positive family/parenting, literacy, etc.

Develop a website – parenting information, community resources, etc.

Promote use of school-based curricula re: parenting, child development, early brain development, etc. (*parenting as life skill*)

WHAT IS NEEDED?

Responses from our community focus groups are summarized in two formats. First is a summary of input received from the group of advocates/interpreters who work with Latino Families with young children. Following this summary is a matrix which enumerates the many observations of community participants regarding what is needed in Shasta County to better the stability of families, the health of young children and the ability of young children to learn. This chart is aligned to the structure of focus areas and strategic results as presented in the State Commission Guidelines.

Frequently mentioned needs and themes of interest/concern which span areas of strategic focus (listed in no order of priority):

- localized, neighborhood-based services and support
- one-stop service centers and systems
- expanded and widely accessible information regarding community services, resources and activities
- expansion of prenatal education, including more focus on areas such as breastfeeding, infant care, substance abuse, tobacco use, disabilities
- support for new parents, with regards to breastfeeding, infant care, infant massage, infant health. Some suggested sources of such support include RN home visits, mentors, telephone services, support groups, playgroups, classes
- widespread parent/caregiver support and education, including focus on stages of development, brain development, discipline, temperaments, play, CPR/1st Aid. Forums for support and education could include classes, home visits, mentors, telephone services
- localized playgrounds, parks and family activity centers
- multilingual and culturally sensitive services
- health insurance coverage available to all families with young children – as a result of the absence or inadequacy of coverage, health care is not sought, preventative measures are not taken and emotionally healthy practices are avoided (“we don’t climb trees or play actively outside because we are afraid of getting hurt and we don’t have insurance . . .”)
- child care – access to quality care for children under 4, children with special needs, and sick children received repeated discussion. The need for affordable child care for the working poor and accessible child care during alternative hours also appeared as significant needs.
- respite care
- child care, health services and recreational opportunities for children 0-3
- capacity-building – training for physicians, mental health practitioners and providers of early care and education; increase supply of physicians for prenatal care and of providers of early care and education
- a responsive transportation system – this repeatedly was identified as a basic need, the absence of which poses a strong barrier to receiving prenatal care, child health care, early care and education, family recreation, and parental support. The lack of adequate transportation for families with young children adds to their isolation

and inability to cope, both of which are precursors to lifestyles and behaviors contraindicating healthy family practices.

- expanded outreach to adolescents including supports and education for teen parents, contraceptive information and education regarding parenting and child development
- 24-hour parent support/health information telephone line – the loss of Redding Medical Center’s *Ask-A-Nurse* is sorely grieved throughout the community. The availability of a parent support/child health line was identified as a support for new parents, a support for family stability and well-being, and a source of access to quality health information
- an array of accessible mental health and counseling services – needs include more professionals trained in infant/toddler mental health; ability to provide intervention to facilitate parent-child attachment; assessment of the family social/emotional situations of mental health clients who are parents of young children; intervention with postpartum depression and maternal depression; relationship counseling for new parents; counseling for young children of divorce, parents of teen parents, siblings, and families with special needs
- recreational facilities, family-oriented events, libraries and literacy programs (including activities for families with special needs; and a variety of cultural events)

FOCUS GROUP SUMMARY
ADVOCATES/INTERPRETERS WORKING WITH PARENTS IN THE LATINO
COMMUNITY
MAY 4, 2000

HEALTH-RELATED OBSERVATIONS/NEEDS

Late entry (maybe?) into prenatal care is more prevalent among Latino mothers
Cultural attitude: pregnancy is natural, no need for care
More perinatal outreach and education in this community is needed
Healthy Families is available only for families here legally
(available through migrant education)
California Kids is defunct – was available for non-residents
CHDP can pay for some treatment identified in check-up (these rules are changing)
Not for chronic condition if not eligible for Medi-Cal
Information about use of medications with young children is needed
Label prescriptions in (accurate) Spanish and English
Provide thermometers for all new moms

TRANSPORTATION – need *demand response* system with Spanish-speaking contact

COORDINATION OF ADVOCATES/TRANSLATORS WORKING WITH LATINO PARENTS IS NEEDED - (perinatal outreach is developing a resource list)

ISSUES RELATED TO IMMIGRATION

50% of SEACM clients are Spanish-speaking
Biggest issue = Immigration
Immigration services/education is needed
People without green card, seeking to renew green card, seeking citizenship
Fear of *being sent back* is significant barrier to seeking and obtaining help with
child health, family health, etc.
No permanent addresses are available for migrant families

CONCERNS RELATED TO DOMESTIC VIOLENCE

Immigration status is used as a form of spousal abuse
Without a green card, where will she end-up?
Spanish-speaking advocate now is available at Women's Refuge
Legal issues are involved with reporting domestic violence
Need anger abatement services

LANGUAGE BARRIERS TO SERVICE

More forms need to be available in Spanish
Need Spanish outreach – domestic violence, immigration
Spanish-speaking home visitors in South County would be helpful
- preventive practices, hygiene, food handling
Spanish assistance at SCOE is needed for speech assessments
No birthing classes in Spanish are available

AVAILABILITY OF SERVICES IN SPANISH ARE NEEDED IN ALL SYSTEMS

DEVELOPMENT OF ENGLISH SKILLS

More easily accessible ESL classes are needed (include transportation)

A green card is necessary to enroll in Shasta College ESL classes

Need to increase personal confidence/motivation to develop English skills

ESL classes are available - need child care, transportation

ISSUES RELATED TO MIGRANTS

For many migrant workers, Spanish is a 2nd language (English 3rd)

Housing for migrants is needed

Washington state has mobile vans which bring health and other services into the field

No time for *joy* with children

Poor nutrition > persistent illnesses

Need food labels in Spanish

Need education regarding food budgeting

CHILD CARE – heavy reliance on license-exempt care

NEEDS FOR AVAILABLE BOOKS AND MATERIALS

Need Spanish/bi-lingual books at libraries

Parenting materials in Spanish are needed

Language tapes

Safety and other pamphlets are available in Spanish

Early Head Start has good bi-lingual pamphlets

Toys, etc. for young children

CAR SEATS

Car seats and car seat education are needed

(class is offered at PHD, translation is available as needed)

\$25 fee – can be prohibitive. Waive?

***WHEN CASE MANAGEMENT IS PROVIDED, MANY OF THE GAPS GET FILLED;
ALLOWS FOR CONTINUITY FOR MEMBERS OF THE MIGRANT COMMUNITY***

NEEDS FOR PARENTAL SUPPORT

Need decreased isolation of moms with young children

No extended family here – no family support – families left in Mexico

Social/recreational/support activities are needed – with transportation included

MENTAL HEALTH RELATED ISSUES

No mental health services are available for Spanish-speaking families

Postpartum depression; stress and anxiety

Few skills regarding ages and stages of early child development

Issues regarding grief & loss (miscarriages, relocation, death of child . . .)
Need child services in Spanish regarding domestic violence
Child therapist is Spanish is needed use of interpreters is not ideal)

ATTENTION TO MALE ROLE

Awareness of male role/involvement in parenting is needed
Support male nurturing (helpful via home visiting)

NEEDS FOR PARENT EDUCATION

Awareness of child development, value of young children
Provide and coordinate parent education opportunities
Offer in local communities – *go where they are*, take educational opportunities *on the road*
Offer in evenings, with food, transportation, child care
Topics including: playing with children, hygiene, nutrition, car seats
Health Fairs are good, well-attended
Family planning

	<u>I. Focus Area</u> Parent Education & Support Services ----- Strategic Result: Improved Family Functioning: Strong Families	AAUW Serendipity	Anderson Head Start	Breastfeeding Peer Grp	Burney	Foster Grandparents	Garden Tract	Infant-Toddler Ctr (Teen Moms)	Kids Turn	MLK Center	Monte Vista	Oak Run	Pvt. Industry Council	Rother School (Southeast Asian Parents)	Salvation Army	Shasta Lake City	Shingletown		Multi-Service Providers	Multi-Service Providers (Inter-Mtn)	PHD Family Health	Family Child Care Ass'n		
	A. Education & Family Support for Pregnant Moms & Newborns																							
1	Prenatal info & encouragement re: breastfeeding	X	X	X				X				X			X		X		X					
2	Support & info to maintain breastfeeding	X	X	X				X							X				X		X			
3	Good breast pumps available for loan	X		X				X																
4	Resource center for breastfeeding moms			X																	X			
5	Prenatal info re: parenting skills & infant care	X	X			X		X	X	X			X		X						X		X	
6	Info about postpartum depression		X																			X		
7	Offer prenatal info re: possibility of special needs		X								X													
8	Support for new moms/parents		X	X					X											X				
9	RN home visits for all new parents		X			X			X				X		X					X	X			
10	Telephone support line for new parents		X												X					X	X			
11	Mentoring program for new parents		X		X				X	X					X					X	X	X		
12	Services & prenatal educ. to decrease perinatal substance abuse				X					X		X			X	X	X							
13	Programs to decrease prenatal use of tobacco									X					X	X								
14	Invite/promote involvement of fathers		X						X	X			X							X				
15	Parent training in infant massage																					X		
16	Send prenatal info when timely appointment for first prenatal visit is not available								X															
17	Contraceptive education & availability for teens							X				X									X			
	B. Education & Family Support to Enhance Parenting & Child Development																							
18	Opportunities for active, practical parent education	X		X	X	X		X	X	X		X			X					X	X	X		
19	Education re: ages & stages of child development	X			X				X	X						X	X				X		X	
20	Education re: brain development	X												X						X				
21	Parent education re: touch & positive affirmations					X																		
22	Education re: child behavior management & discipline		X			X		X				X												
23	Parent education re: managing & expressing emotions/conflict																					X		
24	Parent education re: child temperaments															X								
25	Education for parents re: the importance of play			X																				
26	Pediatric first aid/CPR			X																				
27	Opportunities for father/child play, learning & bonding		X	X					X	X		X	X								X			
28	Info about and for siblings			X																				
29	Family literacy programs			X										X										
30	Emphasis on reading to children	X		X										X							X		X	

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31	More storytelling events in community	X																			X		
32	Book giveaways																		X				
33	Books & reading for kids in MD/other waiting rooms																				X		
34	Linkages between young children & elderly					X															X		
35	Home visiting programs		X			X						X		X						X			
36	Socially developmental interactions for parents with infants/toddlers, young children																X		X				
37	Coordinated, local playgroups (including for children under 3)	X															X			X			
38	Classes/support re: divorce, blended, single parenting	X						X	X			X									X		
39	Education & support for teen moms & dads																				X		
40	Expand/enhance facilities for teen parent/child education																		X				
41	School curricula re: parenting & child/brain development																		X				
42	JR. & SR. High School program for students to serve at family child care sites																		X			X	
43	Pre-12 th grade curricula re: relationships, emotions, conflict management															X			X				
44	Services & support for children with special needs in natural environments																		X				
C. Support for Families for Stability & Well-Being																							
45	Transportation			X		X			X	X		X	X	X	X		X		X	X	X		
46	Respite care for parents/other caregivers		X	X		X		X			X	X			X		X		X				
47	Stress management info/classes	X													X						X		
48	Telephone parental support/info (24 hours)		X	X									X				X		X	X			
49	Local refuge from family violence (i.e. shelters)											X					X			X			
50	Budgeting/money management info														X								
51	Local, fun family educational activities		X												X								
52	Family recreational activities		X												X				X	X			
53	Family fairs, festivals, recreation, education	X	X																	X	X		
54	Cultural opportunities for families																		X				
55	Recreational activities for children with special needs										X												
56	School clothes closet (to reduce stigma of poverty in early school years)												X										
57	Parent to parent support groups	X	X		X			X	X		X	X		X			X				X		

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58	Accessible, neighborhood groups for parental support								X				X		X				X		X		
59	Support/education for grandparents raising children				X	X													X		X		
60	Parent mentors/models		X		X				X	X									X		X		
61	ESL tutoring													X									
62	Incentives/financial support for stay-at-home moms (parents)	X					X	X											X		X		
63	Affordable individual & family counseling				X			X															
64	Relationship counseling for new parents			X				X															
65	Counseling/support for young children of divorced parents								X														
66	Counseling/support for pregnant teens/teen parents & their parents							X															
67	More appropriate foster placement matches					X																	
68	Improved continuity of child foster care placements					X													X				
69	Education & counseling for families with special needs									X													
70	Guidance for families transitioning from TANF				X																		
71	TANF payment to teen parents whose parents don't act in best interest of child							X															
72	Safe, affordable, family-friendly housing		X				X												X	X	X		
73	"Sober living environments" for single parents																				X		
74	Teen parent housing projects							X															
75	Multi-disciplinary teams for "beginning of life" care																		X	X			
D. Consumer-oriented Delivery System																							
76	Info re: available resources (including special needs)		X		X	X			X	X	X	X	X		X				X				
77	Info re: criteria & parameters for services										X												
78	Caregiver advocates to assist access to service systems					X																	
79	One-stop resource/support centers (parent resource center)	X		X					X	X				X			X		X	X		X	
80	Satellite service offices by zip code																		X				
81	Neighborhood structures for connecting people with services																		X		X		
82	Neighborhood parks (parking lot parks)(pocket parks)	X					X	X					X						X	X	X		
83	Drop-in neighborhood activity/meeting spaces	X											X						X				
84	Recreation centers					X																	
85	Supplement library hours, services & learning activities	X	X	X								X	X							X	X		
86	Lending libraries of books, toys, videos, etc.					X				X													
87	More children's library materials/center materials	X								X													

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88	Lending libraries of equipment & toys for children w/special needs										X												
89	Cultural & language materials available for children & families					X																	
90	Book mobiles	X																					
91	Toy/Book swaps	X																					
92	Parenting education on the worksite												X						X				
93	Incentives for employers to address parenting needs	X						X					X										
94	Translators/bi-multilingual services													X									
95	Multicultural awareness in all systems													X									
96	Child advocates in legal system								X							X							
97	Legal system to be more accepting of custody by responsible fathers															X							
98	Increase respect among providers toward parents & parental concerns							X							X								
99	Providers must not seek detachment at cost of ability to address human spirit															X							

	II. Focus Area Child Care and Early Education ----- Strategic Result: Improved Child Development – Children Learning & Ready for School	AAUW Serendipity	Anderson Head Start	Breastfeeding Peer Grp	Burney	Foster Grandparents	Garden Tract	Infant-Toddler Ctr (Teen Moms)	Kids Turn	MLK Center	Monte Vista	Oak Run	Pvt. Industry Council	Rother School (Southeast Asian Parents)	Salvation Army	Shasta Lake City	Shingletown		Multi-Service Providers	Multi-Service Providers (Later Mins)	PHD Family Health	Family Child Care Ass'n	
	A. High Quality Child Care & Early Education Programs																						
100	Well-trained, well-compensated early care & education providers																		X	X			
101	Centralized substitute list for all child care providers																		X			X	
102	Training for early care & education providers																		X				
103	Required training for early care & education providers re: brain development																		X				
104	Training for license-exempt providers				X																		
105	Training for providers re: inclusion & special needs										X								X				
106	Sign language for early care providers										X												
107	Training for Family Child Care (FCC) providers																		X			X	
108	Peer mentoring of FCC providers																					X	
109	Incentives & supports for FCC providers to obtain ECE units																		X			X	
110	“Parenting skills” education for FCC providers w/parents																					X	
111	Well-maintained & supplied early care & education facilities									X		X											
112	Incentives for early care & education providers to upgrade services, facilities, homes																		X			X	
113	Community resources & support for licensed-exempt providers												X										
114	Males in roles in early care & education																			X			
	B. Adequate & Accessible Support of High Quality Child																						
115	More available slots in preschools											X											
116	Longer, more flexible hours of child care (e.g. evenings, weekends)												X		X				X	X			
117	Variety of child care options (e.g. faith based)														X	X							
118	Drop-in child care													X	X								
119	Child care for children under 4; infants & toddlers; not potty trained		X		X	X		X	X					X						X			
120	Full inclusion child care & education programs										X								X				
121	Child care & education for children with impaired										X												

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	hearing																							
122	Care for mildly sick children	X						X					X		X				X					
123	Child care parent co-ops	X	X				X					X					X							
124	Transportation													X	X				X		X			
125	Child care available in the workplace														X				X					
126	Child care near home or work														X									
127	Bi-multilingual child care & education settings													X										
128	Opportunities for cultural diversity in early education settings									X				X										
129	Culturally appropriate food choices in early care & education programs													X										
130	Nanny-care	X																						
131	More programs with comprehensive care			X																				
132	Increase number of FCC homes/providers available				X		X																	
133	Incentives to become FCC provider				X																			
134	Encouragement to involve fathers in classrooms																X							
	C. Affordable Child Care for All Families																							
135	Increased # slots for subsidized child care														X					X				
136	Affordable child care for the “working poor”				X		X	X	X			X	X						X	X				

	III. Focus Area Health and Wellness ----- Strategic Result: Improved Child Health – Healthy Children	AAUW Serendipity	Anderson Head Start	Breastfeeding Peer Grp	Burney	Foster Grandparents	Garden Tract	Infant-Toddler Ctr (Teen Moms)	Kids Turn	MLK Center	Monte Vista	Oak Run	Pvt. Industry Council	Rother School (Southeast Asian Parents)	Salvation Army	Shasta Lake City	Shingletown		Multi-Service Providers	Multi-Service Providers (Inter-Mtn)	PHD Family Health	Family Child Care Ass'n		
	A. Access to Quality Health Services																							
137	Local, multi-service family health clinics								X	X														
138	Telephone line for health information	X							X					X			X							
139	Transportation		X	X				X		X					X					X	X	X		
140	Fill gaps in health coverage: e.g. – over Medi-Cal, no private insurance				X			X			X	X	X	X							X	X		
141	Address needs of uninsured & underinsured	X			X			X			X										X			
142	Increased info re: health coverage resources & options										X		X											
143	Affordable prenatal care				X																			
144	Train MD's re: diagnosis & treatment of postpartum depression		X	X																				
145	MD's need to devote more time to new parents & young children			X													X							
146	Increase supply of OB/GYN, Pediatricians, family practitioners								X															
147	Need more access to early prenatal care								X															
148	Access to prenatal care in outlying areas											X												
149	Extended hours for health care services			X																				
150	After hours emergency care				X																			
151	Prenatal services that are sensitive to teens							X	X															
152	Translators or bi-multilingual providers								X					X						X	X			
153	Encourage male involvement in prenatal & child health		X																					
154	Medical providers need a more holistic approach to the child																X		X					
155	Attitudinal changes of medical profession to invite/encourage parent questions & concerns									X					X		X							
	B. Maternal, Infant and Child Health																							
156	Localized well-baby & health checks & prenatal care									X							X							
157	Early identification of disabilities at well-baby check-ups																X							
158	Allergy testing	X																						
159	Asthma prevention	X								X														
160	Health providers to emphasize effects of prenatal tobacco use on fetus															X								

	III. Focus Area Health and Wellness ----- Strategic Result: Improved Child Health – Healthy Children	AAUW Serendipity	Anderson Head Start	Breastfeeding Peer Grp	Burney	Foster Grandparents	Garden Tract	Infant-Toddler Ctr (Teen Moms)	Kids Turn	MLK Center	Monte Vista	Oak Run	Pvt. Industry Council	Rother School (Southeast Asian Parents)	Salvation Army	Shasta Lake City	Shingletown		Multi-Service Providers	Multi-Service Providers (Inter-Mtn)	PHD Family Health	Family Child Care Ass'n	
161	Non-punitive perinatal services to substance abusing moms															X				X			
	C. Children & Families with Developmental Delays																						
162	Increase ability of providers to make early identification										X	X					X						
163	Infant massage										X								X				
	D. Children & Families with Special Conditions																						
164	Increase info re: the early intervention services										X				X								
165	Decrease use of medication to manage child behavior		X		X	X											X						
166	Physical therapy services										X												
167	Infant massage																		X				
	E. Environmental Health																						
168	Clean air	X																		X			
169	Clean water																			X			
	F. Immunizations																						
170	Make available in localized settings										X												
	G. Nutrition																						
171	Nutrition education in preschools for children & parents			X																			
172	Education re: nutritional aspects of breastfeeding			X																			
173	Parent education re: nutrition; meal preparation & cooking											X					X			X			
174	Education re: prenatal nutrition							X	X		X												
175	More emphasis with pregnant teens/teen parents re: nutrition								X														
176	Parent education re: foods, quantities & eating strategies for age & stages of development																					X	
177	Coordinate recommended requirements of FCC Food Program, WIC, MD's																					X	
	H. Physical Activity and Fitness																						
178	Outdoor recreation spaces in neighborhoods	X																		X			
179	Recreation equipment in parks for very young children	X						X															
180	Physical activities for children at community events	X																					
181	Physical activities for children with special needs										X												
182	Child Gymnasiums		X																				

	III. Focus Area Health and Wellness ----- Strategic Result: Improved Child Health – Healthy Children	AAUW Serendipity	Anderson Head Start	Breastfeeding Peer Grp	Burney	Foster Grandparents	Garden Tract	Infant-Toddler Ctr (Teen Moms)	Kids Turn	MLK Center	Monte Vista	Oak Run	Pvt. Industry Council	Rother School (Southeast Asian Parents)	Salvation Army	Shasta Lake City	Shingletown		Multi-Service Providers	Multi-Service Providers (Inter-Mtn)	PHD Family Health	Family Child Care Ass'n	
		I. Oral Health																					
183	Parent education re: infant/early childhood dental health & prevention		X														X						
184	Info re: infant gum care		X																				
185	Dental care for families on Medi-Cal		X																	X			
186	Dental check-ups for children under 4		X																	X			
187	Shorter delay for dental appointment		X																				
188	Shorter wait at dental appoints		X																				
		J. Alcohol and Other Drugs.																					
189	Address issue of substance abuse around small children									X					X								
190	Maternal detox programs																X						
191	Peer support & education to discontinue substance abuse															X							
192	Mandatory treatment & classes on positive tests on newborns																X						
193	Rehab/treatment programs				X					X													
194	Affordable counseling services				X					X		X											
		K. Tobacco Use																					
195	Decrease smoking around young children									X					X	X							
196	Peer group support & education to stop smoking															X							
197	Supportive health care providers to emphasize effects of 2 nd hand smoke on children															X							
		L. Injury/Violence Prevention																					
198	Family violence counseling												X										
199	Parent & child education re: family violence																X						
200	Increased availability of car seats												X										
201	Provide car seats to community centers									X													
202	Education re: car seat use and installation												X										
203	Home safety education													X									
204	Increase availability of bike helmets												X										
		M. Mental Health																					
205	Parental guidance re: child's emotional health														X								
206	Activities & info to address postpartum depression		X																	X		X	
207	Counseling & support re: postpartum depression		X	X																X		X	

	III. Focus Area Health and Wellness ----- Strategic Result: Improved Child Health – Healthy Children	AAUW Serendipity	Anderson Head Start	Breastfeeding Peer Grp	Burney	Foster Grandparents	Garden Tract	Infant-Toddler Ctr (Teen Moms)	Kids Turn	MLK Center	Monte Vista	Oak Run	Pvt. Industry Council	Rother School (Southeast Asian Parents)	Salvation Army	Shasta Lake City	Shingletown		Multi-Service Providers	Multi-Service Providers (Inter-Mtn)	PHD Family Health	Family Child Care Ass'n	
208	Counseling re: maternal depression		X											X							X		
209	Therapeutic interventions with young children				X							X											
210	Affordable/free counseling																				X		
211	Train mental health providers in infant/toddler mental health																		X				
212	Family assmts to include attachments, child soc/emo sitr																		X				
213	Reorientation of mental health services to emphasize 0-5																		X				

	IV. Focus Area Integrated Systems of Service Delivery -----	AAUW Serendipity	Anderson Head Start	Breastfeeding Peer Grp	Burney	Foster Grandparents	Garden Tract	Infant-Toddler Ctr (Teen Moms)	Kids Turn	MLK Center	Monte Vista	Oak Run	Pvt. Industry Council	Rother School (Southeast Asian Parents)	Salvation Army	Shasta Lank City	Shingletown		Multi-Service Providers	Multi-Service Providers (Inter-Mtn)	PHD Family Health	Family Child Care Ass'n	
214	Include FCC providers w/health & social service providers developing family plans																					X	
215	Decrease discrepancies between med recoms & FCC licensing requirements																					X	
216	Cross-section relationships																			X			
217	Flexibility and collaboration in program policy																			X			
218	Establish partnerships: schools-DSS-NVCSS-Hospitals-Indian Health re: parenting																			X			
219	Partnership Sheriff Office-Health Dept-Shasta College																			X			
220	Single point of entry for all services																		X				
221	Common intake asmt/referral process																		X				
222	Integrated data-base system																		X				
223	Coordination of home visiting/other services								X						X								

"HOW ARE THE CHILDREN?"

APPENDIX D

Shasta Children and Families First Commission

COMMUNITY ASSESSMENT PHYSICIAN SURVEY – APRIL 2000

RESPONDENTS BY PRACTICE SPECIALTY: 1-OB/GYN; 2-Pediatrics; 6-Family Practice

1. From your perspective, what would most improve the health of young children (prenatal to five years old) and their families in Shasta County?

(OB/GYN) - education

(Peds) - improved access to health care – non-emergency room care, 7 days/wk and after normal hours

(Peds) - more access to physicians and specialists; pediatricians who see Medi-Cal families

(FP) -- good food and supplementation

(FP) -- improved mental health services

(FP) -- improved psychiatric services to families, especially for parents, and improved speciality services

(FP) -- education and safety regarding drowning, seatbelts, guns

(FP) -- community education; immunizations

(FP) -- improved ease of access to medical services; improved continuity of care with a single provider

2. Please list the top three issues of Shasta County children 0-5 years old and their families.

(OB/GYN) – money, education, job availability

(Peds) - lack of support from our county government; lack of access to specialty services and needed specialists; single-parent families/unwed mothers without support

(Peds) - Methamphetamine abuse; poverty; affordable child care for both *normal* and special needs kids

(FP) -- diet; activity; health

(FP) -- poor access to immunizations in the private sector often requiring a trip to separate site for vaccines; lack of fluoridation of water and poor access to fluoride supplements; lack of local tertiary pediatric services (#1-psychiatry, #2 neurology, #3 pediatric surgery)

(FP) -- mental illness; domestic violence; drug abuse

(FP) -- safety; preventive medicine (i.e. vaccines, well-child checks); parental guidance

(FP) -- immunizations/dental care; secure families; safety

(FP) -- safety education-violence prevention-family dysfunction; compliance with recommended exams and immunizations; drug abuse

3. What do you believe are the three greatest strengths of health care provision for young children and their families in Shasta County?

(OB/GYN) – it's available, free or cheap, and good

(Peds) - Mercy Maternity Clinic; Shasta County Public Health Department Immunizations; Pediatricians who provide nighttime care for kids in both of our emergency rooms for patients whose doctors don't work at night

(Peds) - availability of pediatricians and specialists through Shasta Community Health Center; access to early intervention services through FNRC; good school nurses

(FP) – parents' knowledge

(FP) – fairly good access to primary care; good secondary care and some tertiary care clinicians especially cardiology and gastroenterology; recent increased access for dental care for Medi-Cal populations

(FP) – primary care services, including immunizations; available health insurance through Medi-Cal or Healthy Families

(FP) – access to health care; availability of vaccinations at no cost/low cost; availability of activities (child friendly parks)

(FP) – a good healthy community; medical availability; good hospitals/physicians

(FP) – fairly good access to quality providers of care; fair availability of programs for low income families; good in-hospital care for children regardless of ability to pay, thanks to Mercy Residency Program

4. Please list the top three needs of Shasta County *families of children with special needs* (i.e. learning/physical challenges).

(Peds)- specialty care available locally; child care; more specialized therapists (PT, OT, Speech and Language; learning specialists)

(FP) – dietary advice; activity advice; medical care

(FP) – psychiatric/psychological assessment is especially unavailable for children even through the school system; tertiary neurology consultation locally; the needs are, if anything, more acute for children without developmental disabilities as this group often has no adequate coverage

(FP) – psychiatric care; improved coordination among primary care, psychiatry, FNRC and schools; specialty care (neurology, ENT); dental services/oral health

(FP) – need specialists in area – difficult to get appropriate pediatric referrals; financial support; no mental health/counseling supports

(FP) – a program to direct/conduct channeled care programs; (what do you do with a CP child with multiple medical problems at age 5? FNRC won't touch them)

(FP) – we need help with children with ADHD and related disorders - speciality consultations are very difficult to obtain; children with mild disabilities (those not qualifying for FNRC services) often can't access help other than with their primary care provider; more pediatric physicians with interest in caring for children with special needs and who are on public aid would be very helpful

5. Please rank in order, with 1 being the highest impact and 13 being the lowest, your opinion of where additional resources would make the most health outcome difference for Shasta County 0-5 years old and their families.

<i>Access to Medical care</i>	1	2	3	4	5	6	7	8	9	10	11	12	13
OB/GYN	NOT RATED.												
Peds	XX												
FP'S		XX		XX									X

<i>Maternal and Child health</i>	1	2	3	4	5	6	7	8	9	10	11	12	13
OB/GYN								X					
Peds			XX										
FP'S	X		XX	X	XX								

<i>Children with Special conditions</i>	1	2	3	4	5	6	7	8	9	10	11	12	13
OB/GYN	NOT RATED												
Peds			X						X				
FP'S	X				X				XX			X	

<i>Developmental delay</i>	1	2	3	4	5	6	7	8	9	10	11	12	13
OB/GYN	NOT RATED												
Peds				X									X
FP'S				X		X		X		X	X		

<i>Environmental health (Second hand smoke, lead-pesticides .)</i>	1	2	3	4	5	6	7	8	9	10	11	12	13
OB/GYN	NOT RATED												
Peds									X		X		
FP'S				XX		X							XX

<i>Immunizations</i>	1	2	3	4	5	6	7	8	9	10	11	12	13
OB/GYN				X									
Peds										XX			
FP'S		X			X			X			X	X	

<i>Nutrition</i>	1	2	3	4	5	6	7	8	9	10	11	12	13
OB/GYN					X								
Peds						X		X					
FP'S	XX					X					X		X

<i>Physical activity And fitness</i>	1	2	3	4	5	6	7	8	9	10	11	12	13
OB/GYN							X						
Peds								X	X				
FP'S		XX							X		X	X	

<i>Oral health</i>	1	2	3	4	5	6	7	8	9	10	11	12	13
OB/GYN						X							
Peds												X	X
FP'S	X					X	X			X			

<i>Alcohol and Other drug use</i>	1	2	3	4	5	6	7	8	9	10	11	12	13
OB/GYN	X												
Peds		X				X							
FP'S			X			X	XX	X					

<i>Tobacco</i>	1	2	3	4	5	6	7	8	9	10	11	12	13
OB/GYN			X										
Peds					X							X	
FP'S		X			X		XX					X	

<i>Violence/injury prevention</i>	1	2	3	4	5	6	7	8	9	10	11	12	13
OB/GYN		X											
Peds				X			X						
FP'S	X			X		X			X				

<i>Mental health</i>	1	2	3	4	5	6	7	8	9	10	11	12	13
OB/GYN	NOT RATED												
Peds					X		X						
FP'S			X	X				X		XX			

"HOW ARE THE CHILDREN?"

APPENDIX E

Community Resources For Prenatal To Five And Their Families

CASE MANAGEMENT PROVIDERS

Anderson Family Center
FaithWORKS
Great Beginnings Family Resource Center
Healthy Starts
Northern Valley Catholic Social Services
Shasta County Public Health Nurses

CHILD CARE PROVIDERS

Child Care Centers
Child Care Resource & Referral
(Early Childhood Services)
Children's Centers
Churches

- Bethel Church
- Little Country Church
- Neighborhood Church
- North Valley Baptist Church
- St. Joseph's Church
- Trinity Lutheran Church

Family Child Care Providers Association
Great Beginnings Family Resource Center
License-Exempt Providers
Rancheria Head Start
Redding Cooperative Preschool
Shasta Head Start/Early Head Start
Some Schools
State Preschools
Tri-County Community Center (Burney)
YMCA

CHILD DEVELOPMENT PROVIDERS

Child Care Resource and Referral Lending Library
Grassroots for Kids
Local Indians for Education
Northern Valley Catholic Social Services
Shasta Head Start/Early Head Start

EARLY CHILDHOOD EDUCATION

California Association for the Education of Young
Children (CAEYC)
CCIP (Child Care Initiative Project)
Early Childhood Services Resource & Referral
Great Beginnings Family Resource Center
Infant & Toddler Training Center (WestEd)
Mary Street School
Migrant Child Education
Montessori Children's House of Shady Oaks
Satellite Classes
Shasta College
Shasta Head Start/Early Head Start
Simpson College

EXISTING COALITIONS/COLLABORATIVES

AREA 1 Perinatal Council
After School Activity Program (Shasta Lake City)
Anderson Partnership for Healthy Children
Association of Non-Profit Professionals
Breastfeeding Coalition
Children's Policy Council
Coalition of Rural Health Care Clinics
Crusaders (Persons with Disabilities Access)
Drug Free Communities Coalition
Education Transition Advisory Committee
Grassroots for Kids
Great Beginnings Family Resource Center
H.I.V. Prevention Planning Group
Health Improvement Partnership
Healthy Starts
Human Rights Commission
IMAGE
Injury Prevention Coalition of Shasta County
Institute for Sustainable Communities
Local Child Care Planning Council
Mental Health Advisory Board
Meth Task Force
North State Independent Living Services
Partnership for the Public's Health
S.C.C.A.R (Shasta County Citizens Against Racism)
S.E.L.P.A. (Special Education)
Shasta CAN (Activity and Nutrition)
Shasta County Alcohol and Drug Advisory Board
Shasta Homeless Coalition
Shasta-Trinity-Tehama AIDS Consortium
Shasta Trinity Trails Connection
Shasta Community Challenge
Shasta County Tobacco Education Coalition

FAITH COMMUNITY

FaithWORKS
Churches (190)
Ministerial Associations

- Shasta County Inter-Faith (SCIF)
- Shasta County Evangelical Ministerial Alliances (CEMA)
- Anderson-Cottonwood Christian Assistance (ACCA)
- Anderson-Cottonwood Christian Leadership (ACCL)

FAMILY LITERACY

English as a Second Language Classes
Even Start Family Literacy Program
R.S.V.P. Literacy Program
Shasta College
Shasta County Library

FAMILY PLANNING SERVICES

Chico Feminist Women's Health Center
Family Planning, Inc.
Mayers Memorial Hospital
Shasta Community Health Center
Shasta County Public Health Department
Shingletown Medical Center
Women's Health Specialist

FAMILY VIOLENCE/PREVENTION ACTIVITIES

Child Abuse Prevention Council
Family Service Agency
Great Beginnings Family Resource Center
Healthy Starts
Helpline
HIP Neighborhood Projects
Kid's Turn
Local Law Enforcement
RESPECT
Shasta County Child Protective Services
Shasta County Community Mental Health
Some Schools
Woman's Refuge
Youth Violence Prevention Task Force

FUNDING SOURCES

California Endowment
California Wellness Foundation
Community Action Agency
David and Lucile Packard
Grant and Resource Center
Health Improvement Partnership--
Community Grants Program
James Irvine Foundation
McConnell Foundation
Mercy Foundation
Service Clubs
Shasta County Public Health Department
Shasta Regional Community Foundation
Sierra Health Foundation
United Way

HEALTH SERVICES

AIM Program
Child Health and Disabilities Program (CHDP)
Comprehensive Perinatal Service Program (CPSP)
Crisis Pregnancy Center
Family Planning Inc.
Healthy Families
Healthy Starts
Hill Country Community Clinic
Medi-Cal for Children and Pregnant Woman
Mercy Medical Center
Mayers Memorial Hospital
Pit River Indian Health
Redding Rancheria
Redding Medical Center

Shasta Community Health Center
Shasta County Public Health Department
School Nurses
Shasta College
WIC

HOME VISITING

Far Northern Regional Center
Great Beginnings Family Resource Center
Mercy Home Visitors
Shasta Head Start/Early Head Start
Shasta County Public Health Department.

JOB/WORKFORCE

Americorps
CalWORKS
College Career/Placement
Employment Development Department
Legal Services of Northern California
Private Industry Council
Small Business Association
Shasta Human Resources Managers
SMART

MENTAL HEALTH SERVICES

Crossroads Clinic
Family Services Agency
Guardian Hospital
Hill Country Community Clinic
Kid's Turn
Northern Valley Catholic Social Services
Private Counseling Services
Shasta County Community Mental Health
Shasta Head Start/Early Head start
Some Schools
Youth Enrichment Services

MENTORING/TUTORING PROVIDERS

Grassroots for Kids
Local Indians for Education
Mary Street School
Neighborhood Policing Unit
Northern Valley Catholic Social Services
Plus One Mentoring
Some Schools

NEIGHBORHOOD DEVELOPMENT EFFORTS

Health Improvement Partnership--
Community Grants Program

- Garden Tract
- IMAGE (Intermountain)
- MLK Neighborhood
- Parkview Neighborhood

Neighborhood Policing Unit
Partnership for the Public's Health -
(Anderson, Shingletown, IMAGE)

NUTRITION

Breastfeeding Coalition
Food Security Coalition
Le Leche League
Shasta CAN
Shasta County Public Health Department.
Shasta Head Start/Early Head Start
WIC

PARENT EDUCATION AND SUPPORT SERVICES

Active Parenting Today
Family Service Agency
Great Beginnings Family Resource Center
High School Parenting Classes
Mary Street School
Mommy Network For New Moms
Montessori Children's House of Shady Oaks
Redding Cooperative Preschool
Sequoia Family Center
Shasta County Child Protective Services
Shasta County Office of Education
Shasta Head Start/Early Head Start

POVERTY SERVICES

Churches
FaithWORKS
Good News Rescue Mission/House of Hope
Habitat for Humanity
Homeless Coalition
Legal Services of Northern California
POP (People of Progress)
Salvation Army
SHHIP

RECREATION & ENRICHMENT PROVIDERS

After School Activities Programs
Anderson Parks and Recreation
Anderson Partnership for Healthy Children
Grassroots for Kids
Healthy Starts
 21st Century/After School & Safe Neighborhood
Kids Kingdom
Local Indians for Education
National Park Service -
 (Whiskeytown and Lassen Park)
Northern Valley Catholic Social Services
Redding Parks and Recreation
Schools
Schreder Planetarium
Shasta Lake City Parks and Recreation
Special Olympics
Turtle Bay Museum & Arboretum
YMCA

SERVICES FOR PEOPLE WITH SPECIAL NEEDS

California Children's Services
Early Childhood Services
 (Shasta Co. Office of Education)
Far Northern Regional Center
Monte Vista School
Nor Cal Services for the Hearing Impaired
Northern Valley Catholic Social Services
Shascade Community Services
Shasta Head Start/Early Head Start

SUBSTANCE ABUSE PREVENTION PROVIDERS

Chemical People
Crossroads Clinic
DARE
Pit River Health Services
Schools
Shasta County Alcohol & Drug Programs
Shasta County Tobacco Education
Women's Refuge

SUBSTANCE ABUSE TREATMENT PROVIDERS

Crossroads Clinic
Faith-based Programs
Family Service Agency
HIP-Community Grants Program
Shasta County Alcohol & Drug Program

- Perinatal Program (Trinity House)
- Outpatient Services

TEEN PARENTING SERVICES

Adolescent Family Life Program
Early Head Start Infant-Toddler Parenting Center
Life Light
Mary Street School
North Valley Continuation School
Teen-Age Parenting Program (TAPP)

TRANSPORTATION

See attached list

TRANSPORTATION IN SHASTA COUNTY (1999)

AGENCY	PASSENGER VEHICLES	MILE/ MO	TRIPS PER MO.	HRS.	SERVICE AREA	# OF CLIENTS	FIXED/ DEMAND
RABA (REDDING AREA BUS AUTHORITY)	19 Buses	70,000	71,000	M-F 6:30 AM-7:30 PM, Sat 9:30 AM-7:30 PM	REDDING, ANDERSON, SHASTA LAKE AREAS	_____	FIXED
SHASTA-TRINITY INDIAN RURAL HEALTH PROJECT	4 7-PSGR VANS	10,000	400	M-F 8:00 AM-5:00 PM	SHASTA & TRINITY COUNTIES	5,000 TOTAL 50 DISABLED	DEMAND
SHASTA COLLEGE	8 BUSES, 6 VANS	12,000	4,000	M-F 6:00 AM-6:00 PM	SHASTA, TRINITY & NORTHERN TEHAMA	250 STUDENTS DAILY	FIXED
GOLDEN UMBRELLA	2 STATION WAGONS 1 9-PSGR VANS	4,000	711	M-F 8:30 AM-4:00 PM	GREATER REDDING AREA	14,900 SENIORS 150 DISABLED	DEMAND
HEAD START	3 MINI-BUSES 5 9-PSGR VANS	27,000	540	M-F 7:00 AM-5:00 PM	SOUTH CENTRAL REGION, SISKIYOU & TRINITY	364 36 DISABLED	DEMAND
SHASCADE CMMTY SERVICES	14 TOTAL 9-PSGR VANS 38 PSGR BUSES	15,000	7,826	M-F 6:30 AM-5:30 PM	SOUTH CENTRAL REGION	182 DAILY	DEMAND
COUNTY SCHOOLS	26 BUSES	55,586	135,000	M-F 5:30 AM-5:30 PM	SHASTA COUNTY	436 DAILY	DEMAND
SENIOR NUTRITION	5 MINI-BUSES 11 VANS 1 STATION WAGON	33,500	9,200	M-F 8:00 AM-5:00 PM	RURAL & URBAN AREAS	1,127 MONTHLY	25% FIXED 75% DEMAND
STILLWATER LEARNING CENTER	1 BUS, 3 VANS 1 SEDAN 1 P/U TRUCK	8,360	1,400	M-F 8:00 AM-5:00 PM	ANDERSON, REDDING & SHASTA LAKE	200+	DEMAND
PIT RIVER INDIAN HEALTH	2 14-PSGR VANS 1 6-PSGR VAN 1 7-PSGR VAN	7,000	1,080	8:00 AM-5:00 PM	SHASTA, SISKIYOU, MODOC & LASSEN COUNTIES	512	DEMAND
V.A. TRANSPORT	1 12-PSGR VAN	4,000	240	M-F 5:30 AM-6:00 PM	SHASTA, SISKIYOU, TRINITY, TEHAMA & BUTTE COUNTIES	3,500 VETERANS	DEMAND
PRIVATE	1 15-PSGR VAN	3,000	800	M-F	SHASTA & TEHAMA COUNTIES TO CSU CHICO	20-25/ SEMESTER	VANPOOL
FAR NORTHERN RETIONAL CENTER	ALL CONTRACT SERVICE (ABC CAB, MAYFLOWER, ETC)		19,000	M-F	SHASTA, SISKIYOU, TEHAMA, LASSEN, GLEN, BUTTE, MODOC, PLUMAS & TRINITY COUNTIES	2,500 DEVELOP- MENTALLY DISABLED	DEMAND

"HOW ARE THE CHILDREN?"



Shasta Children and Families First Commission

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